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REPORT OF THE COMMISSION ON MEDICAL CARE PLANS

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

COMMISSION ON MEDICAL CARE PLANS

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WILLIAM P. SHEPARD, M.D.
New York, New York

NORMAN A. WELCH, M.D.
Boston Massachusetts

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PREFACE

This report of the Commission on Medical Care Plans of the American Medical Association is the culmination of a three and one-half year study of the various types of medical care plans throughout the United States. The 15-member Commission was appointed by the Board of Trustees on November 29, 1954 to determine whether current medical care plans are effectively promoting 1) the highest quality of health services, 2) the welfare of the public and the medical profession, and 3) the ethical standards of the medical profession.

The Commission reviewed three broad areas:

1. The nature and method of operation of the various types of plans through which persons receive the services of physicians.
2. The effect of these plans on the quality and quantity of medical care provided.
3. The legal and ethical status of the arrangements used by the various plans.

It also sought to determine:

(a) What effect, if any, these plans have on the traditional patient-physician relationship.

(b) Whether the introduction of a third party in this relationship tends to disturb it and to result in an inferior quality of medical care.

(c) Whether there are plans in which the participating physician is violating the Principles of Medical Ethics.

(d) Whether the plans will encourage the corporate practice of medicine, especially by hospitals.

(e) What the proper relationship, if any, should be between the medical profession and all these third-party financial mechanisms.

The Commission has recognized the need for objective inquiry into some of these highly controversial areas. The six previous progress reports of the Commission reflect the efforts made to assure the collection of objective information to support conclusions and recommendations. It made every effort to ascertain the facts, to report impressions as they were received, and to formulate opinions founded upon impartial evaluation. There has been a continuing awareness that its recommendations could serve as a basis for the further formulation of the profession's attitudes toward the various types of medical care programs.

No attempt has been made to develop a "blueprint" or so-called ideal form of medical care program, nor to argue the merits of one particular type of plan over another. The medical profession is fully aware of the increasing pressures for expanded medical services at lower costs to the public. The efforts of the profession are second to no group in striving to provide medical care of the highest quality. Medicine is therefore confronted with both a challenge and an opportunity; the challenge of assuming its proper role in demonstrating that voluntary programs for medical care can narrow the remaining gaps of care and cost, and the opportunity of welcoming and encouraging experimentation by making available the counsel and leadership it is willing to assume and is capable of generating.

Developments within these recent years have amply demonstrated that medicine is on the threshold of new scientific discoveries. The expanding horizons of medicine must be matched by the profession's ability to assist in making these improved standards of care available to all who would avail themselves of them.

The Commission's study has attempted to summarize and correlate the various points of view, attitudes, and opinions of groups directly concerned in the provision of medical care. It presents information which has not been made available heretofore. It recommends possible solutions to perplexing problems. It also raises questions which have yet to be answered.

The members of the Commission who have grappled with these questions and issues deserve our gratitude for the devotion to the difficult task assigned to them by the Board of Trustees and the House of Delegates. They have helped to push aside misunderstanding and have substituted light where, sometimes, heat has prevailed.

We know that many problems remain unsolved, but we hope that this report will be a constructive addition to the many profound observations regarding the patient-physician relationship that previous Houses of Delegates have considered and enunciated.

Leonard W. Larson, M.D.
Chairman

September 22, 1958

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PART I

FINDINGS, CONCLUSIONS

AND

RECOMMENDATIONS

INTRODUCTION

This study is devoted primarily to an examination of those voluntary medical care plans and programs, other than hospitalization plans, through which people receive the services of physicians for surgical and medical care. Prepayment plans represent the majority of those studied. However, other types of plans such as occupational health programs (including non-occupational medical care programs in industry and workmen's compensation) and student health services are included in order to permit the examination of certain characteristics and problems as they affect the relationships between patient and physician, patient and plan, and physician and plan.

This report is the product of numerous interviews, field studies, and conferences with representatives of local and state medical societies, individual physicians, and others. It has drawn upon the varied experiences and knowledge of the members of the Commission, and has utilized the results of a number of surveys and compilations prepared by the staff.

The research projects which provided the Commission with statistical data and other background materials were[1]:

1. A detailed study of a group of prepayment plans, characterized as "miscellaneous and unclassified plans," to secure comparable data on structure, method of organization and operation, medical services provided, and other significant characteristics. This report contains an analysis of 107 such plans with an enrollment of over 3.5 million persons, and the results of a number of field studies of 19 plans in ten cities. A directory of 246 plans known to the Commission, with some salient characteristics, is also included.

2. A review of the laws relating to the miscellaneous and unclassified plans, including a description of the relevant internal structure of the American Medical Association.

3. An analysis of Blue Shield plans to provide information on the characteristics of these prepayment mechanisms and their benefit schedules for the 29 most common surgical procedures. This report contains an analysis of the characteristics of the most widely held and most liberal certificates issued by 64 Blue Shield plans with an enrollment of almost 27 million persons.

4. An analysis of the characteristics of 19 medical society approved plans, other than Blue Shield, with an enrollment of 3 million persons.

5. A study of the contract provisions of the most widely held and most liberal policies issued by insuring companies for group regular medical and surgical expense. This report contains an analysis of the provisions of contracts issued by ten such companies with an enrollment of over 24 million persons covered for surgical expense and more than 13 million for regular medical expense benefits.

6. A similar survey among insurance companies writing individual and family surgical and regular medical expense policies. This report includes information on contracts issued by 21 such companies enrolling an estimated 40% to 50% of all persons covered by such policies.

7. A survey among almost 3,000 medical directors and physicians of in-plant medical programs to determine the characteristics of industry programs concerned with occupational health and the medical and ethical relationships involved. This report contains information on 244 such programs serving almost 1.5 million employees.

8. The use of the same study schedule to secure information with regard to occupational disability programs (workmen's compensation). This report summarizes the responses of 201 employers with 860,000 employees.

9. A compilation of selected statutory provisions of workmen's compensation laws.

10. An analysis of some monetary aspects of workmen's compensation.

1. *These studies and compilations, with the exception of item 11., are included in Part II of the final report, which was distributed to the House of Delegates prior to the 1958 Annual Session in San Francisco.*

11. A review of the pertinent literature pertaining to student health services.

12. The preparation of a compilation integrating policy statements of the House of Delegates with Judicial Council decisions relative to pertinent sections of the Principles of Medical Ethics from 1847 through December, 1957.

The members of the Commission were divided into four committees by the Chairman in order to apportion the responsibilities for supervising the different research projects and to enable various Commission members to concentrate their efforts on specific areas of study. The full Commission, however, reviewed and acted on all projects and reports submitted by the individual committees. The formulations, conclusions, and recommendations embodied in this report reflect the opinions and judgment of the Commission as a whole (except where reservations or qualifications are noted) rather than those of any individual member or of the members comprising a specific committee.

The areas of study and the members of the Commission responsible for them were:

1. Miscellaneous and unclassified plans, and student health services: H. Russell Brown, M.D., Chairman; John F. Conway, M.D.; F. J. Elias, M. D.; and Leo Price, M.D.

2. Medical society and related plans, including Blue Shield, and private insurance programs: Percy E. Hopkins, M.D., Chairman; E. J. Faulkner; Jay C. Ketchum; and Norman A. Welch, M.D.

3. Industry programs providing non-occupational medical care, and occupational disability programs: William P. Shepard, M.D., Chairman; David B. Allman, M.D.; and H. Gordon MacLean, M.D.

4. Policy statements of the House of Delegates and Judicial Council opinions relative to pertinent sections of the Principles of Medical Ethics: Homer L. Pearson, M.D., Chairman; Joseph D. McCarthy, M.D.; and James R. Reuling, M.D.

The Commission's *Second Progress Report*[2], approved by the House of Delegates at the 1956 Annual Session, cited the completion of what the Commission considered to be the first phase of its work; namely, the measurement of the major quantitative and historical aspects of its study. It also called attention to the fact that the Commission was faced with the more formidable task of establishing criteria for the quality of medical care provided and for other qualitative aspects for which questionnaire techniques were not suitable. At the suggestion of the Board of Trustees, the members of one of the committees, together with the Chairman of the Commission in several instances, undertook a series of field trips to a number of major cities in which representative plans were located in order to secure additional information.

Discussions with physicians serving various types of programs, together with meetings of officials and other representatives of local and state medical societies, enabled the Commission to grasp more clearly the issues and problems involved in providing medical care to members of the miscellaneous and unclassified plans, and in the legal and ethical aspects of the plans' operations. This was augmented by inspections of the physical facilities and equipment of the plans, or of some of their units, studied (to the extent that time permitted), examination of records, and intensive questioning regarding various features of the programs for which the questionnaire surveys could not have been designed.

The amount of time spent on the total study was therefore determined by the extent to which information became available to the Commission, by the recognition that different facets of the study required more time and effort and research than had originally been anticipated, and by the fulfillment of the objective that conclusions and recommendations would be valid only when supported by thorough and impartial documentation and observation, to the degree that this was possible.

Before considering the conclusions and recommendations reached and the findings in the different areas of study undertaken, it might be well to point out that a study of the nature attempted cannot conceivably answer all of the questions which have arisen in the past, or which may be posed in the future, with regard to the multitude of medical care plans in existence. The Commission has endeavored to deal primarily with those elements and issues which, over the years, have appeared to be matters of particular interest and concern to the medical profession and which have tended to create a divergence of opinion regarding various aspects of medical care provided by or through these programs. The resolutions referred to the Commission by the Board of Trustees and the House of Delegates in 1954 were of assistance in this regard in that they focused attention on some of the issues to be considered by the Commission. They were, accordingly, discussed at great length during the course of study. However, since the Commission considered that these resolutions had been referred to it for informational purposes only, no action was taken on them other than the one noted in its *First Progress Report*.[3] At that time, the Commission recommended approval by the House of Delegates

2. *"Second Progress Report of Commission on Medical Care Plans" (Proceedings of the Chicago Meeting, June 11-15, 1956), J.A.M.A. 162:485-486 (Sept. 29) 1956.*

3. *"Supplementary Report of Board of Trustees: Progress Report of Commission on Medical Care Plans," J.A.M.A. 159:1370-1379 (Dec. 3) 1955.*

TABLE 1.

Scope of the Commission's Study

Area of Study	Inception of Program	No. of Persons Involved* (Millions)	No. in Commission Study (Millions)	Relationship of Patient to Program	Relationship of Physician to Program	Benefits Provided by Program
In-plant non-occupational medical care programs	Late 1800's	15.0 (approx.)	1.4	No choice (majority of programs)	Salary, contract, fee for service	Ranges from first aid to comprehensive medical care
Miscellaneous and unclassified plans	Late 1800's	5.5 (approx.)	3.6	Ranges from choice of physician to no choice (majority: choice of physician within panel)	Salary, contract, fee for service	Ranges from diagnostic to comprehensive medical care
Student health services	1861	1.0 (approx.)	957 college health programs	Ranges from choice of physician to no choice (majority: no choice)	Salary, contract, fee for service	Ranges from first aid to comprehensive medical care
Occupational disability programs (workmen's compensation)	1911	40.0-45.0	0.8	Ranges from choice of physician to no choice (majority: no choice)	Salary, contract, fee for service	Ranges from limited benefits and duration to unlimited medical benefits
Medical society approved plans (other than Blue Shield)	1939	3.5	3.0	Choice of participating physician	Fee for service	Surgical and medical
Blue Shield	1940	34.4	26.7	Choice of participating physician	Fee for service	Surgical and medical
Private insurance	1940's (major development)	39.0 (group) 22.5 (individual) (approximate)	24.3 (group) 10.0 (individual) (approximate)	Choice of physician	Fee for service	Surgical and medical

*As of dates surveys were conducted.

of the following resolution,[4] which had been proposed by the Council on Medical Service:

WHEREAS, The medical profession is dedicated to the provision of medical care in the public interest; and

WHEREAS, It is essential in providing the best medical care to the public that the profession be concerned not only with the planning of facilities but also with the maintenance and improvement of standards therein; and

WHEREAS, The experience of the Council on Medical Service indicates that benefits may accrue to the public by encouraging state and county committee activities in this field; and

WHEREAS, The profession recognizes that the community has a vital concern regarding the availability and operation of medical facilities, and

WHEREAS, Medical facilities are being sponsored or established by non-medical groups in some areas; therefore be it

RESOLVED, That constituent associations and component societies be encouraged to designate committees whose functions may include but need not be limited to:

1. Maintaining continuous studies with respect to existing health facilities as well as needs;

2. Consulting with groups having an interest in health facilities; and

3. Advising groups or individuals interested in sponsoring, establishing or improving health facilities.

4. *Adopted at the 1955 Clinical Session as a substitute for Resolution No. 12 ("Resolution on Relationship Between Component County Societies and Lay-sponsored Health and Welfare Plans"), which had been introduced at the 1954 Clinical Session by Dr. James Z. Appel of Pennsylvania.*

The accompanying chart indicates the variety of programs studied, their dates of entry upon the panorama which the Commission was asked to view, the number of persons involved in these programs, the number included in the plans studied, the range of patient-physician-plan relationships within these programs, and the scope of medical services offered. A cursory inspection of these components cannot begin to tell the story of the variety of forms of medical practice which even such presumably well-known mechanisms assume. Thus, as the essential ingredients of each program were separated and analyzed, the complexity of the study became increasingly apparent. Each area of study presented different problems, different historical aspects, different social, economic, and ideological concepts, and different methods of operation—all of which have influenced in shaping and molding the attitudes and opinions of individual physicians and, at times, those of the profession as a whole.

It should be borne in mind that when the Commission reviewed the developments in each area of study and attempted to answer the questions which were posed by the objectives previously mentioned it was constantly alert to the issues and problems which have entered into the considerations of the local medical

societies, the House of Delegates, and the Judicial Council, as well as the motivations of individuals and groups other than the medical profession who are directly involved in these programs. Conclusions and recommendations are therefore based upon a complexity of factors, all of which are interrelated.

The format and organization of this report have been dictated by the Commission's desire to make it as compact and concise as possible. The material selected for publication is that which has been considered of sufficient value and importance for the Board of Trustees and others to review and study. It is presented in a form which enables the reader to secure the benefit of the Commission's deliberations and then to proceed to greater detail if he so desires.

This final report has been published in two parts. Part II, issued separately, contains the statistical data and background materials which were developed by the staff of the Commission. This volume, Part I, contains the reports of the various committees as adopted by the Commission, as well as the conclusions and recommendations reached.

DEFINITIONS EMPLOYED BY THE COMMISSION

These plans, which may provide physicians' services in the hospital, home, office, or clinic, directly, or reimburse the members for such services, fall into three groups. They were defined by the Commission on the basis of the method of payment for physicians' services and the relationship of the member of the plan to the physician:

A. Cash indemnity.—Plans designed to assist persons in paying the cost incurred for medical care. Such plans allow maximum specified sums not necessarily related to the insured's expense for the specified services. The insured may go to any physician of his choice.

B. Service or full payment.—Plans designed to assure the patient that any medical service included in the plan will be provided in either of two ways: (1) through so-called open-panel arrangements where any physician may participate if he agrees to accept the fees listed in a predetermined schedule of benefits; or (2) through closed-panel arrangements where medical services are usually provided by physicians the number of which is determined by the plan. These latter are employed on a salary, hourly, or other contractual basis. Such plans may be (a) open to the general public, or (b) limited to a specific industry, union, or other circumscribed group. The patient may or may not have a choice of physicians within the closed panel.

C. Combinations of indemnity and service or full payment.—Plans combining various aspects of cash-indemnity and service-or-full-payment plans as described above.

These definitions represent slight modifications of those originally adopted by the Commission as contained in its *First Progress Report*. The original definitions attempted to differentiate plans primarily according to relationships between the physician and the plan while also indicating methods of payment for medical services. Those given here place primary emphasis on the method of payment. Although either set of definitions would be valid, and although other definitions would perhaps be equally acceptable, the ones listed were decided upon because they would be more widely understood and more easily compared with other studies.†

†*The analysis of the 107 plans in Appendix A of Part II are based upon these definitions.*

REPORTS

OF

COMMITTEES

miscellaneous and unclassified plans

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FOREWORD

This report contains the results of the committee's study of the group of voluntary medical plans designated by the Commission as miscellaneous and unclassified. These plans may be broadly characterized as those self-insured programs which provide or pay for physicians' service in either the home, hospital, office, or clinic, or any combination of such services. They are not ordinarily identified or associated with other forms of voluntary medical care prepayment plans, such as medical society approved plans, including Blue Shield, or those of private insurance. Although some of the miscellaneous and unclassified plans provide for physicians' services on the same basis as that of the voluntary prepayment programs with which most physicians are familiar, the majority offer direct medical services to the members through closed panels of physicians.

Plans within this miscellaneous and unclassified group may be sponsored or financed by employers, employees, unions, health and welfare funds, consumer or community groups, fraternal organizations, physicians in private group practice, or some combination of such sponsors.

Coverage in these plans at the end of 1954 constituted less than 6% of all persons covered by medical and surgical expense benefits in all forms of voluntary medical care programs. However, their type of organization and sponsorship, their methods of financing and of providing medical services, their scope of benefits and legal background, and their patient-physician-plan relationships make them of special interest to the medical profession.

The results of the study are based upon two questionnaire surveys conducted by the committee responsible for this phase of the Commission's inquiry and on a series of field trips in which a cross-section of plans was visited and numerous interviews were conducted with physicians and lay administrators employed by these plans and with representatives and officials of local and state medical societies.

One phase of the committee's study deals with the characteristics of 107 of the approximately 250 plans believed to fall within the scope of its inquiry. The survey findings are reported in Appendix A of Part II of this report. The enrollment in the 107 plans represents 3.6 million of the estimated 5.5 million persons covered by such plans at the end of 1954.†

A more complete description of the methodology employed in securing information for this report is contained in this and in succeeding sections. Appendix A also contains a review of the origin and development of the miscellaneous and unclassified plans, outlining their historical background and citing examples of the different forms they have taken.

The following chapters describe the methods employed by the committee in securing information from physicians serving these plans and from their lay employees through visits to a number of facilities and through meetings with members and committees of local and state medical societies in the areas visited. These chapters contain the numerous observations made by the committee on various elements and characteristics of the plans as observed during these visits to 19 plans in ten cities. They discuss laws relating to these plans, and contain the conclusions of the committee, based upon its findings.

The first task of the committee and staff involved searching out and listing some 250 plans believed to come within the scope of the committee's study. Data were first obtained in the early part of 1955 on an initial group of 212 plans with an enrollment of 4.9 million persons by questionnaire and from other sources. These data were reported in the Commission's *First Progress Report*. A second, more detailed questionnaire was employed in December, 1955, through which more complete information was secured from 107 plans with an enrollment of 3.6 million members and dependents.

The information provided by the 107 plans was coded and recorded on IBM cards. The characteristics of these plans were then analyzed in accordance with the definitions and classifications originally adopted by the Commission in February, 1955. At a subsequent meeting of the committee, held in January, 1957, a modification of the definitions adopted by the Commission was considered necessary by the members of the committee. The analyses of the 107 plans as contained in Appendix A of Part II are therefore based upon these subsequent modifications. This was done in order to present the data in a manner consistent with current usage of terms to designate plans of different types and different methods of payment for services rendered.

After the committee had analyzed the replies which miscellaneous and unclassified plans made to the committee's questionnaires, it reported to the Commission that this information could be considered an adequate sampling of the approximately 250 plans in existence. The returns were felt to represent a cross-section of the different programs and contained detailed information on enrollment, type of sponsorship, method of financing, medical services rendered, organizational structure, and other quantitative elements included in the first objective of the Commission's study. However, when an attempt was made to evaluate other characteristics of these plans in order to fulfill the objectives of the inquiry related to ethical and professional relationships, it was found that additional research techniques would have to be employed.

The recommendation of the committee for a field study of a cross-section of these plans was concurred in by the Commission and reported to the Board of Trustees. In its supplementary report which the House of Delegates approved in June, 1956, the Board of Trustees recommended that "the Commission explore first the possibility of conducting further inquiry by interviews, visits, or some other pilot-study techniques among a group of representative plans and medical societies. This approach would delineate those areas and elements with which it is concerned and assist it in arriving at criteria for further evaluation of these plans."

The committee proceeded immediately to arrange visits to several cities in which representative plans were located. In each of these areas meetings were held with physicians who represented component societies or constituent medical associations and who were interested in the study. Plan medical directors, representatives of lay administration, and individual participating physicians were interviewed. Interviews

†*As this portion of the report is being prepared for publication, the total number of persons reported enrolled at the end of 1957, by all types of voluntary mechanisms, by category of benefit was: Hospitalization—123 million; Surgical expense—109 million; Regular medical—74 million; Major hospital and medical—13 million.*

were also held with chiefs of clinical services, specialists, and generalists, including full-time and part-time physicians, all of whom were associated with these plans or under agreement to render medical services to be furnished or paid for by the plans. Visits to the plans involved an inspection of their equipment and facilities and an examination of various types of records in addition to the meetings mentioned above. The observations based upon these visits and interviews are contained in the following chapter.

As previously mentioned, although the group of miscellaneous and unclassified plans contain some indemnity and service programs similar to those offered by Blue Shield and private insurance, in which the traditional patient-physician relationships are retained, the majority of programs provide medical services through closed panels. This committee, therefore, devoted a major portion of its efforts to the evaluation of closed-panel plans, particularly when the study of the 107 plans revealed that over 70% of the plans, with over 85% of the enrollment, were concerned in some measure with the closed-panel practice of medicine.

These plans, which may provide physicians' services in the hospital, home, office, or clinic, directly, or reimburse the members for such services, fall into three groups defined by the Commission on the basis of the method of payment for physicians' services and the relationship of the member of the plan to the physician:[5]

1. Cash indemnity.—Plans designed to assist persons in paying the cost incurred for medical care. Such plans allow maximum specified sums not necessarily related to the insured's expense for the specified services. The insured may go to any physician of his choice.

2. Service or full payment.—Plans designed to assure the patient that any medical service included in the plan will be provided in either of two ways: (1) through so-called open-panel arrangements, where any physician may participate if he agrees to accept the fees listed in a predetermined schedule of benefits; or (2) through closed-panel arrangements, where medical services are usually provided by physicians the number of which is determined by the plan. These latter are employed on a salary, hourly, or other contractual basis. Such plans may be (a) open to the general public or (b) limited to a specific industry, union, or other circumscribed group. The patient may or may not have a choice of physicians within the closed panel.

3. Combinations of indemnity and service or full payment.—Plans combining various aspects of cash-indemnity and service-or-full-payment plans as described above.

The following sections of the report attempt, therefore, to present the various characteristics, relationships, and other significant findings as they concern these plans from their early beginnings to their present stage of development. The use of any plan name is for illustrative purposes only; the omission of any name is not to be interpreted as ignoring or minimizing the plan's existence or the service it renders.

The committee believes that these visits and interviews have enabled it to develop a better knowledge of the facilities, methods, and techniques utilized by these plans to provide medical care than could otherwise have been obtained. It learned something of the level of the qualifications of the physicians serving these plans and of the characteristics and general attitudes of the patients served. The committee feels that it would have been very difficult in any other way to have obtained a fair appraisal of the thinking and opinions of the physicians in these areas, and an estimate of the quality and quantity of the plans' services to those enrolled, or to have reached conclusions regarding the ethical and legal considerations involved in the activities of these plans.

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5. As previously indicated, these definitions represent slight modifications of those originally adopted by the Commission. The original definitions attempted to differentiate plans primarily according to relationships between the physician and the plan while also indicating methods of payment for medical services. Those given here place primary emphasis on the method of payment. Although either set of definitions would be valid, and although other definitions would perhaps be equally acceptable, the ones listed were decided upon because they would be more widely understood and more easily compared with other studies.

1. FIELD STUDIES AND OBSERVATIONS

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INTRODUCTION

Between June 28, 1956, and October 4, 1957, the committee, accompanied in most instances by the Chairman of the Commission, made 27 visits to 19 plans in ten cities.[6] Some local units of plans with multiple facilities were not visited. The total enrollment of the plans visited was more than 2.6 million of the 3.6 million persons covered by the 107 plans reporting in the survey, and more than 47% of the estimated enrollment of 5.5 million in all the plans of this type at the end of 1954. Seventy-three physicians, including medical directors, and 12 lay administrators employed by or serving these plans were interviewed in the course of the inspection of facilities, equipment, and records of these plans. In some instances, additional physicians who were on duty at the time of the visits were asked questions about their work. The results of this study are discussed in subsequent pages of this report.

Several other physicians were also interviewed about four other programs with which they were currently or had been previously associated. The committee also interviewed at considerable length the chairman of the Committee on Medical Care for Industrial Workers, who has been directly involved over the past seven years with a number of the programs and problems being considered by the Commission. His observations and the documented records of that committee's activities were particularly helpful in filling in some of the gaps in our own information, especially as they related to areas which the members of the Commission had not visited.

6. The committee has included in this count the visits to several facilities of particular plans. Although the medical groups of two large plans visited are separate and distinct entities, they have been treated as a unit in describing the characteristics of the plan with which the groups are commonly identified.

TABLE 2. **Plans Visited by the Committee**

Location and Name of Plan	Type of Services Provided	Enrollment	Date of Visit
New York City			
Union Health Center, International Ladies' Garment Workers' Union	Diagnostic and ambulatory medical care	155,000	June 28, 1956
Consolidated Edison Employees' Mutual Aid Society	Comprehensive medical care	25,000	June 29, 1956
New York Hotel Trades Council and Hotel Association Health Center, Inc.	Diagnostic, ambulatory, and in-hospital care	34,000	June 29, 1956
Medical Department, Pension Committee of the Joint Industry Board of the Electrical Industry	Diagnostic service only	7,000	June 29, 1956
Health Insurance Plan of Greater New York (three medical groups and administrative headquarters)	Comprehensive medical care	500,000 (Enrollment in three groups is 78,600 or approximately 15% of the total)	June 30, 1956
St. Louis, Missouri			
St. Louis Labor Health Institute	Comprehensive medical care	15,000	August 16, 1956
Garment Industry Medical Center, ILGWU	Diagnostic and ambulatory medical care	5,500	August 16, 1956
Chicago, Illinois			
Sidney Hillman Health Center	Diagnostic and ambulatory medical care	12,000	September 17, 1956
Union Health Service, Inc.	Comprehensive medical care	8,500	September 17, 1956
Chicago Health Center, ILGWU	Diagnostic and ambulatory medical care	10,000	September 17, 1956
Union Eye Care Center	Diagnostic and ambulatory ophthalmological care	80,000	September 18, 1956
Beckley, West Virginia			
Beckley Memorial Hospital (United Mine Workers of America Welfare and Retirement Fund)	In-hospital, office, and out-patient medical care on a specialist level	(See UMWA below)	April 1, 1957
Washington, D. C.			
UMWA administrative headquarters	(See UMWA under Beckley, West Virginia)	1,000,000	April 2, 1957
Labor Medical Center	Diagnostic and ambulatory medical care	24,000	April 2, 1957
Group Health Association, Inc.	Comprehensive medical care	22,000	April 3, 1957
San Francisco Area, California			
Permanente Medical Group (San Francisco, Oakland, Walnut Creek)	Comprehensive medical care	315,000	September 30, 1957
Southern Pacific Hospital Department	Comprehensive medical care	74,500	October 2, 1957
Palo Alto, California			
Palo Alto Medical Clinic and Stanford University Student Health Service	Comprehensive medical care	10,900	October 1, 1957
Los Angeles, California			
Southern California Permanente Medical Group	Comprehensive medical care	230,000	October 3, 1957
Ross-Loos Medical Group	Comprehensive medical care	120,000	October 4, 1957
Pacific Electric Railway Hospital Association	Comprehensive medical care	5,700	October 4, 1957
		Total 2,654,100	

Before visiting any of the plans, the committee notified the appropriate county and state medical societies of the visit and its purpose. Complete cooperation of the medical societies was obtained. They assisted both in arranging for such visits and in organizing meetings with officials, executive secretaries, and other representatives of the societies.

The physicians who represented the local and state medical societies were either presidents, past presidents, trustees, secretaries, or chairmen of medical economics committees, union health center committees, health insurance committees, grievance committees, or UMWA liaison committees, as well as physicians serving these plans. All of them were members of the medical profession who, in one way or another, had some experience with the types of plans under consideration.

Listed in Table 3 are the locations where such meetings were held, the dates of the committee's visits, and the number of physicians attending each meeting.

TABLE 3.

Meetings with Officials and Representatives
of County and State Medical Societies

Location		No. of Physicians
New York City		
Five county societies and the state society	June 28, 1956	12
St. Louis, Missouri		
St. Louis Medical Society and Missouri State Medical Association	August 15, 1956	12
Chicago, Illinois		
Chicago Medical Society	August 17, 1956	9
Charleston, West Virginia		
County medical society	March 31, 1957	4
Beckley, West Virginia		
County and state medical societies	April 1, 1957	9
Washington, D. C.		
Washington Medical Society	April 2, 1957	6
San Francisco, California		
California Medical Association; San Francisco, Almeda-Contra Costa, San Mateo, and Solano county medical societies	September 29, 1957	13
San Joaquin County Medical Society	September 30, 1957	4
San Jose, California		
Santa Clara County Medical Society	October 1, 1957	8
Los Angeles, California		
Los Angeles County Medical Association	October 2, 1957	12
	Total	89

Each meeting, whether with medical society representatives or with physicians at the plans visited, was preceded by a detailed explanation of the purpose of the committee's study as a part of the Commission's assignment. In each instance the chairman of the Commission or the chairman of the committee expressed the committee's desire to secure all the information necessary for a factual and objective report. There was free and full discussion. The committee asked all questions it felt were necessary to screen fact from hearsay and to explore the basis of opinions expressed.

This method of conducting meetings was particularly productive in that it enabled the members of the committee to evaluate various comments in the light of their own observations during the visits to plans and during their subsequent discussions with medical societies. The committee heard many expressions of appreciation from within and without the societies for the objective manner in which the study was being made and for the interest of the A.M.A. in the problems under consideration, as well as of the hope for recommendations which could serve as guides to all concerned.

These comments were of special interest to the committee in view of the fact that in at least three cities, the committee was told, little or no contact had been established between the medical societies and these plans. These discussions appeared to stimulate greater interest on the part of both the plans and the medical societies in effecting closer working relationships for the purpose of either providing or seeking guidance and direction.

There appeared to be just as many physicians in the plans who were uncertain of the true purpose of the Commission's study and the committee's visits as there were representatives of some medical societies. With the limited time available to make these studies, it was a task requiring a great deal of tact to secure the cooperation of all persons involved in getting a true picture of the status of these plans and the effectiveness of their operations.

Before visiting each plan the committee acquainted itself with information which would be of assistance in evaluating the program, including as much background information as was available to it regarding the plan's nature and method of operation. This information was assembled from the responses to the Commission's questionnaires, from articles, brochures, and publications issued by or about the plans, and from material published in various publications of the American Medical Association and other medical societies. With this background of information the committee was better equipped to conduct its field trips and discussions.

In an attempt to arrive at some determination of the quality of medical care rendered by the plans visited, the committee felt the need for a definition of good-quality medical care and for a list of criteria which could be applied to the characteristics of each plan.

For the purpose of this research, the committee defined good-quality medical care as that service which uses every means available to secure and maintain a state of physical and mental well-being in the individual. Good-quality medical care results from the full use by the physician of his art, skill, and knowledge, and his utilization of the scientific facilities available to him. It depends upon the physician's sincere interest in his patient and the patient's faith in his physician.

In attempting to appraise the quality of medical care in the plans visited, it was necessary to develop a list of criteria. These are included in the table of contents of this chapter (page 13) and are more fully discussed on the following pages. Thus, in its visits the committee examined facilities, equipment, and in almost all instances, records as well. It discussed the scope of the medical services provided and the qualifications of physicians, and reviewed many other aspects of the programs, including hours of service, methods of financing, professional relationships, and characteristics of the membership groups served by the plans.

The committee believes that it has studied representative operations of all the plans visited and that the method followed during the field trips enabled it to reach valid conclusions with respect to the organization and significant operations of the plans visited. The limitations of time did not permit exhaustive exploration of every facet of each plan. The committee could not observe the examination of patients in every plan.

The committee has attempted to avoid excessively detailed descriptions of the plans in this chapter. It has highlighted those facts and elements which will enable any person not thoroughly acquainted with the various characteristics of these plans to secure the advantages of the committee's observations.

PHYSICIAN PARTICIPATION IN POLICY DECISIONS OF GOVERNING BOARDS

Many physicians believe that direct participation in policy decisions is necessary, particularly where policies are determined which may directly or indirectly influence the medical service rendered. Others feel that staff representation on the governing board, if accompanied by voting privileges, places the physician in a difficult position should a factional dispute develop. In *"Guiding Principles for Evaluating Management and Union Health Centers,"*[7] which was approved by the A. M. A. House of Delegates in Boston in November, 1955, and revised in Philadelphia in December, 1957, the Committee on Medical Care for Industrial Workers recognized this problem by stating:

> It is desirable that the governing body shall be composed not only of representatives of the lay group which furnishes the funds, representatives of the medical staff, and the medical administrator, but may also include representatives of the community. Its composition may be subject to the laws of the respective states . . .
>
> The center should have a full-time or part-time medical director who is a qualified doctor of medicine. He should have charge of the medical administration and participate, ex officio, in the deliberations of the governing board.

Among the 107 plans surveyed, almost one-third indicated that the medical staff is consulted on policy decisions through either the medical director or the plan's consultant. Over 40% of all plans with some element of closed-panel direct-service arrangements have medical staff representation on policy-making bodies. This representation is accomplished in several ways, among which are the following: medical directors are either members ex officio, without vote; have the right to attend meetings, without vote; are invited to attend meetings, or the advice of the staff is sought in other ways.

The committee's visits revealed that the medical director participated in the deliberations of the governing board in 12 plans. (The governing board in two plans was composed of the physicians in the medical partnership operating the plan). Seven plans did not provide for such participation. Among the 19 plans, at least 4 provide for medical representation on their boards of directors by physicians who are not employed by the plan. In 3 plans their appointment to the board is a legal requirement of the enabling act of the state (Illinois), which requires that at least 30% of the board of directors must be physicians and that the medical director shall participate in the deliberations of the board without the right to vote.

PHYSICIAN PARTICIPATION IN POLICY DECISIONS ON THE STAFF LEVEL

The methods and extent of staff participation in decisions affecting policy are usually determined by the medical directors of the plans.

In three plans visited by the committee the medical director alone established policy on a staff level and supervised medical services. In 16 others the staff physicians met with the medical director at various intervals to discuss and determine medical policy. In 9 of these 16, specially selected groups of staff members were appointed by the medical director or the staff to represent the staff in policy decisions. Thus, in one plan, a medical control board was composed of 24 members, consisting of the chief of each specialty service plus three physicians elected by the general medical staff. In one plan, the by-laws made provision for a professional association of staff members to determine medical policy as well as to serve as a grievance and negotiating committee. In one plan a medical audit committee reviewed records and made its recommendations to the medical director. The committee learned that in four plans there was a decentralization of administrative and professional responsibilities among the staff members through various committees formed to assist the medical director in the establishment of

7. *"Report of Council on Industrial Health and Council on Medical Service" (Proceedings of the Atlantic City Meeting, June 6-10, 1955), J.A.M.A. 158:837 (July 9) 1955.*

medical policy. In the medical group of one plan, the physicians have organized themselves into a guild which acts in behalf of the physicians on various professional and policy problems, including remuneration and working conditions.

The methods described above are exclusive of those discussed in the next section.

MEDICAL ADVISORY COUNCILS

The committee's study of 107 plans inquired into the presence of medical advisory councils. Such councils or committees may be established by plans to assist the governing board and the medical director and his staff by recommending various administrative, professional, and technical procedures, by passing on the qualifications of physicians, by acting as a mediation or grievance committee, and by serving in other consultative capacities whenever needed by the medical administrator. These councils or committees are usually composed of physicians who are prominent in their specialties in the community or who have established reputations in organizational or institutional activities. Occasionally, staff physicians, other than the medical director will be represented on such committees.

The majority of the 107 plans (over 54%) were found not to have medical advisory councils. If plans with exclusively open-panel arrangements are excluded, it is found that approximately half of the closed panels have such councils.

In the plans visited by the committee, four providing ambulatory care and seven providing comprehensive care did not have such committees. One of the medical directors felt that the presence of two physicians on the board of directors of his plan obviated the need for an advisory committee; others felt that they were capable of maintaining high-quality medical service without such councils.

The remainder of the plans visited have such councils and utilize their services in a number of ways. One plan has a 20-member council which includes the medical director and three chiefs of staff of the center appointed by, and representing, all chiefs of staff. Members of the council may be removed by a vote of the majority of the board of directors at any special meeting, but this decision must be concurred in by a majority vote of the advisory council itself. The duties of this council are to promulgate rules and regulations relating to professional and technical services, to examine qualifications of physicians recommended by the medical director, to hear and adjudicate disputes between patients and physicians with respect to professional and technical services, and to make recommendations to the board of directors. Any decision of the advisory council on a professional matter may be overruled by the board of directors only with the concurrence of a majority of the members of the council. The executive committee of the council acts for it between its meetings. The medical advisory council has several standing committees dealing with (1) professional standards; (2) records, statistics, and costs; (3) public relations; (4) grievances; (5) health education and preventive medicine; (6) committee reports; and (7) policy.

Another plan has what it calls a medical control board, composed of 15 members who are appointed from nominations made by medical groups (5), from the academy of medicine (1), and from county medical societies (if they choose to make such appointments, which they do not), together with 2 medical members of the board of directors. The medical control board has issued a publication outlining various professional standards for physicians to be employed, types of records to be maintained, reports to be submitted, types of professional services to be provided, and conditions under which they are to be rendered. The standards describe in general terms the administrative organization of medical groups, the composition and size of the medical staff, the functions of physicians serving the medical groups, and various definitions of the 12 basic specialty services offered. The standards also contain recommendations regarding locations, office hours, physical facilities, and equipment. The medical control board may, for cause, make exception to its standards.

One of the complaints voiced to the committee by several physicians working in the different medical groups of this plan was that the groups did not have sufficient voice and representation on the medical control board. This advisory group has been engaged in studies on the quality of medical care which have been carried out by the plan among its medical groups.

LAY DOMINATION

In all but two plans visited, the governing boards were composed predominantly, and in most cases entirely, of lay persons. This organizational structure could, of course, lead to lay domination of medical matters despite procedures adopted in some plans to give physicians a voice in management.

A large number of physicians interviewed (including some affiliated with these plans) were concerned about this possibility. This concern was based on the conviction that physicians alone are qualified to determine medical policies. The inherent danger in the organizational structure of the plans is that lay persons may influence the quality and quantity of medical care and determine the facilities, equipment, drugs, or method of treatment which will be employed. One means of

doing so is to control expenditures, particularly compensation to physicians.

Most of the plans visited employed lay administrators. Lay administrators also present the possibility of lay domination. It is fully recognized that the business affairs of a plan should be in the hands of a competent administrator. In some plans the chief administrator is a physician who has the over-all responsibility for both medical and business matters. In conducting business affairs he may be assisted by lay employees. In many plans, however, a layman is the business administrator whether he be called an executive secretary or a business manager or by some other title. In plans that use promotional material, the lay administrator often has considerable authority with respect to its content. It is possible that the power and dominance of such a position may affect medical practice unfavorably.

In the plans visited, the members of the medical staffs interviewed stated that they had experienced no lay domination in their particular plans. One medical director's comments were to the effect that there was never any "conscious interference" by the board of directors and that any problems of this nature which arose were satisfactorily resolved. The medical directors of two groups associated with one plan cited examples of attempts at lay domination at various times which they had been successful in resisting. The guild in the one plan previously referred to was organized by the physicians in order to prevent lay interference which, the committee was informed, has never materialized.

The committee, in the course of its field trips, observed no lay interference with the rendition of medical services. In some instances, however, the committee believed that the lay administrator interfered with the medical staff in the latter's efforts to furnish information sought by the committee.

COMPOSITION AND PAYMENT OF THE PROFESSIONAL STAFF

Composition of the professional staff varies considerably among the plans. The committee sought to determine the status of the physicians employed by the plans visited, their method of payment, and the amount of remuneration.

In one diagnostic plan, there are seven part-time board-certified physicians. Each one receives $10 per hour. The medical director also serves on a part-time basis; his salary was not indicated.

One ambulatory medical care program employs approximately 12 full-time physicians, 67 part-time physicians in general medicine who receive between $5.00 and $7.50 per hour, and 93 part-time consultants who receive from $6.00 to $19.50 per hour. Half-time physicians (20 hours per week) receive $4,000 to $8,000 per year plus vacations, sick leave, hospitalization insurance, and other fringe benefits. Two specialists at this center, both chiefs of sections, told the committee that they felt compensation should be better.

One ambulatory medical care plan employs approximately 184 physicians. In addition to the full-time medical director, there are approximately 30 general practitioners, 137 specialists, and 16 consultant specialists. Hourly rates of pay are $6 for general practitioners, $10 for specialists, and $25 for directors of services.

Ophthalmologists in one ambulatory plan receive $10 per hour.

In one ambulatory medical care plan the range of payment to 17 part-time physicians is from $6.41 to $12.11 per hour. Board-certified physicians start at $9 per hour. The medical director is part-time; his salary was not indicated.

One ambulatory medical care plan employs 30 part-time board-certified physicians. They receive $9 per hour to start, $9.50 after one year's service, and $10 after two years.

One ambulatory medical care plan employs 27 part-time physicians at $8.50 per hour. The medical director is half-time (20 hours).

The five physicians in one ambulatory medical care plan are on a partnership basis. Consulting surgeons and specialists are on a fee-for-service basis.

In one plan, approximately 6,800 physicians are approved to render medical and surgical care. Physicians are either on a fee-for-service or retainer basis; no breakdown is available since retainers are agreed upon between the individual physician and the plan. The plan did, however, have figures on full-time employment in its hospitals, and on remuneration. The hospitals employ 120 full-time physicians. House physicians (residents and general practitioners) receive between $12,000 and $14,000. Board-eligible physicians' salaries range from $15,000 to $16,500. The range for board-certified physicians is from $17,000 to $25,000, depending upon age, specialty, experience, and other factors. All physicians receive annual increments up to five years of service. They may attend two national and one state professional meetings a year with compensation. A non-contributory pension plan provides physicians $300 per month, in addition to OASI benefits, at age 65 after 20 years of service. There is also a provision for retirement at age 70 after 15 years of service.

The following information applies to employment and remuneration in nine comprehensive plans.

One plan has over 150 physicians, including 4 full-time and 31 part-time, 49 district physicians, and 58 consultant specialists. Part-time physicians receive between $5.50 and $10.25 per hour. District physicians and consultants receive fees for service. Full-time physicians are on salary.

One plan's medical groups employ a total of 1,000 physicians. The groups operate, in the main, on a partnership basis. An undetermined number of physicians who are not partners are on a salary basis. Physicians in certain specialties whose services are used for special cases receive fees for service. In one medical group visited, 33 of the 42 physicians are partners; 9 of these non-partners have one-year contracts. Salary for the latter starts at $7,500 and goes up to $9,000. A point system is used to determine each partner's share of the income. In another group visited, most of the 32 physicians are partners. Remuneration is based upon a formula which considers experience, length of service, hours of work, and number of services rendered. Various maximum limits are imposed by these groups on the last factor in order to discourage physicians from taking advantage of the formula. In another medical group visited by the committee, 26 of the 30 physicians are partners and 4 are on contract. Physicians may see their non-insured private patients at the clinic. They pay the group 30 percent of their gross income from this outside source, up to a maximum of $150 per month, for the privilege of using these facilities.

In one plan, over 50 part-time physicians are employed. Most physicians are paid on an hourly basis which is computed on a "going annual rate," the minimum being $12,574 for internal medicine. Surgeons and physicians in certain specialties are paid a straight salary computed on a maximum basis of $18,000 per year and scaled downward according to specialty.

In one plan, 18 full-time and 18 part-time specialists are employed. Full-time physicians' salaries range from $10,000 to $12,000 per year, with yearly increments of $300 up to a maximum of $3,000. Consultants are on a fee-for-service basis.

The committee was informed by some physicians that their salary or hourly rates compared favorably with the going rate in the community. They also noted that they were relieved of customary office expenses, and were satisfied with the payment received. Other physicians stated that they felt that hourly rates should be increased.

One plan employs a part-time medical director, 49 part-time board-certified or board-eligible physicians, 43 residents, and 23 interns. It has arrangements with 640 local physicians who provide out-patient care in various areas in which employees live. Part-time physicians average $7,200 yearly for about half-time work. Most of the local physicians are on a fee-for-service basis; a small percentage are on retainer.

One plan has a half-time medical director, a full-time general practitioner, and 15 part-time board-certified or board-eligible physicians who serve in the clinic. Their hourly pay ranges from $8 to $25, depending on specialty. One hundred physicians serve as a panel to provide emergency and ambulatory care in outlying areas. Of these, 90% are on a fee-for-service basis; the others are on retainer.

One plan has a total of 90 full-time physicians; 62 are partners and the remainder are "probationers" on salary. After one year's service, probationers can be voted into the partnership by the partners. More than half of the physicians are board-certified. Members of the staff have every other week-end off, one month's vacation, and six months' additional vacation after every six years of service. It should be noted that this group is in the private practice of medicine. About 10% of its income is derived from its prepayment plan.

One plan has 110 full-time physicians; 32 are partners, 45 are "participating" physicians, and the others are on straight salary. Participating physicians are those who have been employed for three years or more but who are not partners. They may participate in the profits of the partnership. The average income of the medical staff, exclusive of the medical director, ranges from $13,000 to $15,000. Participating physicians may conduct a private practice in the plan's clinics. Half of the income from private practice is kept by them; the other half goes to the partnership and is distributed among the partners and the participating physicians yearly. A few part-time physicians are also employed, as needed.

One medical group has over 300 full-time physicians including 142 partners. Of the 300, 80% are board-certified or board-eligible. The average income of the partners is $18,000 per year. Other salaried physicians receive an entrance salary of from $900 to $1,000 per month, depending upon specialty. They receive a $100-per-month increment after the first year and a $150 increase in the third year. Increments for partners are determined according to a point system. Salaried physicians are eligible for partnership in the fourth year. Some physicians are employed on a fee-for-service basis to make house calls in outlying areas. Members of the group receive extra remuneration for the use of their cars. They participate in a vacation program and receive sick leave and time for educational meetings.

Another medical group in the same plan has 200 full-time physicians; 79 of these are partners and the remainder are on salary. The income range of the physicians is from $800 to $2,300 per month. Most of the physicians are board-certified or board-eligible. A small number of residents are employed in the plan's hospitals.

SCOPE OF THE PROGRAMS AND OF THEIR RESPONSIBILITIES TO PATIENTS

The scope of some prepayment programs has been described as "comprehensive medical care." This has

sometimes been construed to mean that complete medical care is provided in the office, the home, and the hospital. It implies that a subscriber does not have to pay additional fees for any medical, surgical, or ancillary service.

In its study, the committee found on its visits to miscellaneous and unclassified plans that this objective was not met. For example, additional fees were frequently charged for house calls, injections, medications, laboratory services, and other procedures; treatment for tuberculosis or psychiatric care was unavailable; services were unavailable because of the distance of a subscriber's home or work location. Particularly in a hospital, professional service varied considerably. There may be ward, semiprivate, or private care with a variety of relationships with physicians, some of whom were previously unknown to the patient. There usually is no provision for special nursing care. There may be limitations on medications, diagnostic services, or length of stay in the hospital. Another factor is the lack of opportunity for the subscriber to secure the full advantage of the many phases of medical care at a convenient location and at a convenient time.

Therefore comprehensive medical care, as defined above, is not available to most subscribers under the plan. This is of particular significance when the cost of services on a fee-for-service basis and with free choice of physicians is compared with the cost of care provided by prepaid closed-panel service plans.

The excluded features in a prepaid medical care plan may not be clearly stated or understood by the subscriber. The subscriber is thus frequently not in a position to decide whether conventional medical care through private practice with a more free choice of physician meets his needs better than a plan which purports to be comprehensive but makes additional charges for some services.

Among the plans visited, one provides diagnostic and ambulatory services to members, four provide ambulatory medical care to members, and three provide such services to members and dependents. Four plans provide comprehensive medical care to members, and six provide such services to members and dependents. One plan provides complete in-hospital and office care on a specialist basis to members and dependents. Hospital services of this last plan are available, upon request, on a flat-rate basis, to people of the community who are not plan members.

To varying degrees the plans provide for physical examinations, including history-taking, urinalysis, blood counts, blood serology, x-rays, and other tests as indicated at the initial visit or in return visits to the physician. Medical and surgical care is provided, varying in extent with the scope of each program. Eight plans which provide comprehensive medical care require surgery to be performed by part-time or full-time physicians employed on the staff. One comprehensive plan assigns the member as a patient to the chief of a clinical service of any one of 34 hospitals in the city. The medical groups in one comprehensive plan will permit outside physicians to perform surgery in the plan's hospital if they are judged to be qualified, but the patients must pay for such services. One comprehensive plan refers its patients to the hospital of another plan.

Plans providing ambulatory medical care vary in the responsibility assumed for surgery or obstetrical care. In five plans the patient may select any surgeon of his choice in the community. In two, the patient is required to select a staff surgeon, or one is selected for him by the plan.

In one plan, the patient has a choice of surgeon only among those approved by the plan, although in a few areas most surgeons are approved.

Many of the plans visited provide medications and injections on the premises. Five plans provide drugs without cost to the patient. Most have an additional charge.

The types of services varied in the plans observed. Thus, dental care, physiotherapy, social services, general health examinations, eye examinations, and nutrition services are present in some plans.

Provisions governing home calls vary markedly among the comprehensive plans. Most require the patient to pay fees for such calls. One plan furnished the service without charge but required the patient to clear the request through the administrative office at specified times. Different methods of controlling this service were used in other plans.

RELATIONSHIPS WITHIN THE MEDICAL STAFF

The degree to which physicians participate in the determination of medical policy on the staff level, in various activities relating to technical services, and in the medical management of patients is reflected in varying arrangements and procedures among the plans visited.

In most plans, regularly or irregularly scheduled meetings are held by the medical director and the members of the staff, with major responsibility assumed by the medical director.

In one diagnostic-ambulatory plan the medical board representing the staff meets bimonthly to consider questions involved in medical procedures, to establish standards and criteria for recording medical findings, to recommend changes in the formulary, and to advise on other matters. When a surgical operation is recommended for the patient, the medical director refers the case to an internist for concurrence.

In another such plan, the presence of three chiefs of

services on the medical advisory council seeks to achieve the same objectives, and is considered an aid in improving professional relationships.

The medical director of one comprehensive plan meets regularly with a guild composed of physicians on the staff of the plan. The guild discusses various professional matters which arise in the course of the work of the physicians and their relationships to the medical service.

One medical group holds staff meetings monthly with both salaried physicians and partners. In another plan, the partners meet monthly.

Two medical groups of one plan hold quarterly staff meetings of the entire clinic group and weekly meetings of each department. One of these groups conducts a weekly training program among its generalists. In the past three years, 78 physicians have left the staff of one of these groups. The committee was informed that 31 of these were not rehired because they did not measure up to the standards set by the group, 17 went into military service, seven went into residencies(two of these are being endowed by the group), and 23 left of their own accord to go into private practice.

In one comprehensive plan with numerous medical groups the physicians are aware of the professional standards developed by the medical control board. Plan officials report that patient complaints are given special attention by the plan and that efforts are made to correct their causes. The plan has conducted studies in an effort to appraise the quality of medical care rendered by physicians in its medical groups. According to the plan, these surveys have resulted in the termination of the services of some physicians and in the correction of a number of deficiencies in the management of cases. The surveys indicated that more family physicians were taking care of hospitalized patients, and that more complete case workups were being done by such physicians. It was also stated that more effective liaison resulted between the family physician and specialists in the plan and that more systematic procedures have been developed to follow up patients who did not keep appointments for various services.

In four comprehensive plans, the medical director has committees of staff members to give advice and guidance on all professional matters and to advise on the administrative coordination of all sections.

In one diagnostic-ambulatory plan, the medical director refers a patient for whom the internist recommends surgery to one of three surgeons for confirmation of the diagnosis. The surgeon may operate if the patient so desires—in which case the surgeon must accept the stipulated fee in full payment. Physicians on the closed staff may also make home calls at the patient's request and expense.

In two comprehensive plans, three surgeons perform all the surgery. One of the plans refers the patients to surgeons on the basis of hospital staff appointments, specialties, etc.; the other assigns cases on a rotating basis.

In six comprehensive plans, physicians on the staff make house calls on a rotating or assigned basis; three of these also employ some non-staff physicians for this purpose. In four other comprehensive plans home calls are made by outside physicians. One of these plans has so-called district physicians; three have arrangements with a number of general practitioners in several areas of the city.

In one diagnostic-ambulatory plan, physicians render medical care on a fee-for-service basis to members as a private group practice and establish professional and administrative policy among themselves.

In one plan, lists of "approved" specialists are maintained in different areas of the country. (Approved physicians are those who will be paid by the plan for medical or surgical care rendered to beneficiaries). These physicians are paid by the plan either in a fee-for-service basis in full payment or on a retainer basis (salary for part time). Physicians have been removed from these lists by some medical representatives of the plan when, in the opinion of the representatives, they were performing surgery for which they were not qualified, over-hospitalizing patients, performing unnecessary surgery, or overcharging the plan. In a recent report to the House of Delegates, the A.M.A. Committee on Medical Care for Industrial Workers stated[8]:

> . . . The Fund has thereby excluded from its approved lists other physicians in some areas who are admittedly well qualified to perform such services. Furthermore, the Fund has also excluded from its approved lists some surgeons who are board certified. The Fund has also removed some accredited hospitals from its lists of acceptable institutions and retained some which are not accredited.

It has been reported that some approved physicians have not been able to render in-hospital medical care to the plan's members because the plan withdrew approval of the only hospital in which the physician had staff privileges. In other instances, approved physicians have not been able to render medical care to beneficiaries of the plan when hospital staffs have denied them staff appointments or where medical societies have not admitted them to membership. For the most part, only board-certified surgeons and members of the American College of Surgeons may render care to plan members in the hospital.

Approximately 6,800 physicians in 26 states are on

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8. *"Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund" (Proceedings of the New York Meeting, June 3-7, 1957), J.A.M.A. 164:1114 (July 6) 1957.*

this plan's approved lists as "participating" physicians.[9] Its chain of ten hospitals has a basic staff of full-time physicians. Approximately 225 local physicians in the areas covered by the hospitals have appointments on various hospital staffs. All hospitals have out-patient departments. Any general practitioner may hospitalize his patient and be paid for services for which he is approved. A physician will not be paid for obstetrical deliveries in the home, but will be paid for this service in the hospital.

Staff members of the plan's hospitals may render in-hospital and out-patient care to private patients on a fee basis. These practices are justified by the plan on the ground that its facilities should be available to the community generally. On the other hand, restrictions are placed on the acceptance of indigents for such care because the Fund is set up solely for the benefit of its members.

Medical policy in the hospitals is determined by physicians on the plan's administrative staff, with some consultation of the plan's medical advisory committee.

The executive medical officer of the plan establishes broad medical policy; this policy is interpreted and implemented by his administrative staff and the medical representatives of the plan, designated as area medical administrators. The latter are given, or assume, varying degrees of autonomy and latitude in establishing policy with the members of the medical profession in their areas of jurisdiction. For example, in addition to establishing lists of approved "specialists" (who may or may not be board-certified), they may issue lists of drugs which physicians may prescribe, and which certain patients may receive without additional cost. Although physicians on "preferred" lists may prescribe drugs for their patients without receiving prior approval from the area medical administrator, all other approved physicians must have their prescriptions approved.

Although descriptions of some of the mechanisms and characteristics of this plan go beyond the title of this section, they serve to illustrate how the relationships within the medical staff can be affected. They highlight, further, the existence of certain problems which are discussed later in this chapter.

9. *In October, 1957, a large number of physicians and an unknown number of hospitals in several states were removed from the plan's lists. The reason for this reduction, as given by the executive medical officer of the Fund, was as follows: "The records and data of the Trust Fund, based on the past nine years of operation and experience, afford conclusive evidence that quality of service rendered to its beneficiaries, and conservation of its resources, can be maintained most effectively by limiting payments, for services to Fund beneficiaries, to physicians and hospitals whose services are most needed. To meet the mandatory requirement of conserving Trust Fund resources, and providing authorized services to beneficiaries, Trust Fund payments are hereby restricted to physicians and hospitals whose services are deemed necessary and essential" (Memo dated Sept. 10, 1957, to area administrators). On June 16, 1958 the executive medical officer of the Fund stated that, "Under this provision there is still a wide choice of physicians. In the course of the first 7 months it has been in effect, the services of more than 5,000 physicians have been available to beneficiaries and more than 5,000 physicians have received payments from the Fund." (Address at National Conference on Labor Health Services, Washington, D.C.)*

RELATIONSHIPS BETWEEN PLAN PHYSICIANS AND MEDICAL SOCIETIES

In almost all areas visited by the committee, physicians serving these plans are accepted for membership in local medical societies. In a few areas, some of the physicians serving certain plans have been accepted for membership but others working for the same plan have not, although in some areas they have recently been accepted in increasing numbers. Generally, admission to membership in local medical societies has appeared to depend, among other factors, on the type, scope, and sponsorship of the plan, the area in which it is located, and the length of time the plan has been in operation.

In one local medical society, one member of the ethics committee is a physician affiliated with a plan some physicians of which had not been accepted for membership at the time of the committee's visit. In several areas visited by the committee, plan physicians are officers of local or state medical societies or members of society committees.

In one area, however, the committee was told that physicians who serve a particular plan on a retainer basis, although admitted to membership, are not eligible to hold office. In two areas, the committee learned, certain friction still exists between plan physicians and physicians who are not serving the plans. Differences of opinion centered around ethical considerations with respect to the plan's activities rather than the professional qualifications of the physicians involved. In one area some opposition to a closed-panel plan was removed when the plan offered prospective members the choice of another plan in which the patient could select any physician in the community.

Although complaints with regard to advertising had been made in the past against two physicians in two plans, these have since been resolved.

RELATIONSHIPS WITH OTHER PHYSICIANS IN THE COMMUNITY

In one plan providing diagnostic service only, patients may be treated by their family physicians, to whom the results of their tests are sent. If the patient has no family physician he is encouraged to select one in his community.

The members of six diagnostic-ambulatory medical care plans are encouraged to obtain their own physicians, to whom laboratory reports are sent at the patient's request. Treatment is rendered for those conditions which generally do not require hospitalization or long-term care. Where complications are likely to develop, or where the treatment for a condition is considered to extend beyond that provided at the health center, the patient is asked to see his family physician. In some cases, the medical director contacts the family

physician to acquaint him with the type of care rendered. Where members of plans do not secure their own family physicians, it is apparent that the health center continues to treat cases with which a family physician might otherwise be concerned.

In four of these same plans, the patient has the choice of any surgeon in the community. However, he may also select the surgeon at the health center, who usually charges fees which are reported to be lower than those ordinarily charged. In the fifth plan, the patient can use an outside surgeon if the medical director approves the patient's selection and if the surgeon agrees to accept the fee set by the plan.

In two plans, the patient may select any surgeon in the community or one of those in the center, but in one case the fee schedule must be accepted on a full-payment basis. In the other, the fee is accepted on a service basis by surgeons in the center, but if the patient goes to an outside surgeon he must pay the difference between the benefit schedule and the surgeon's charges.

Patients in one comprehensive plan may secure home calls from general practitioners who are designated as district physicians. To the extent that these physicians are not on the full-time or part-time staff of the plan they may broadly be considered "outside" physicians. Actually, however, the member's choice of such physicians is limited. Although the district physicians in this case charge lower fees for home calls in return for the additional volume of work they receive from the plan, the member must receive approval from the plan before each house call.

Another plan which does not provide house calls will assist the patient in obtaining a physician selected by the plan for this service at specified rates at the member's expense.

In one comprehensive plan, about 10% of the patients have choice of physician for all services since they live outside of areas served by the medical groups of the plan.

In one plan, patients have a choice of specialist from among those on the plan's list of approved physicians[10] (in some areas most specialists are approved). "Choice" in this case applies to those physicians who will be paid by the plan for medical and surgical services on a specialist level. (In this and the other plans the member may, of course, go to any physician of his choice. But if the physician is not on the part-time or full-time staff, or approved by the plan, the patient must pay for such medical care himself. The one exception among those visited is the plan which will reimburse the patient according to a schedule of benefits regardless of what facilities he uses or what physician he selects). The plan referred to at the beginning of this paragraph will also pay general practitioners who hospitalize their patients for obstetrics in its hospitals.

Two comprehensive medical care plans have arrangements with panels of physicians in the community to provide emergency and ambulatory care to members. These physicians are on a fee-for-service basis for the most part, although about 10% are on retainer. The medical groups of another comprehensive plan have extended courtesy privileges in their hospitals to many physicians in two different areas. One of the groups reported that 32% of its hospital patients are hospitalized by private practitioners; another group reported that about 2% of the deliveries in its hospital were made by private physicians.

Most plans make provision for the patient to secure the services of any physician in the event of out-of-area emergencies.

EXTENT OF PHYSICIAN SELECTION BY PATIENTS

The preceding section contains some over-all observations regarding the patient's freedom to select physicians either outside or within the plan. This section deals more directly with the extent of physician selection within the plan itself.

In most of the plans visited there is no or little choice of physician initially, particularly where the first examination is made, or where the member is referred to one of the specialists by a plan physician in general medicine. Choice of either a "family" physician or a specialist or surgeon naturally is limited by the number of physicians serving the closed panel and available at the time, but such choice of physician is accorded the patient in these plans if he wishes to change to some other doctor. Such a change is based on the patient's ability to visit the plan when that physician is on duty. At least five plans do not provide the patient with a choice in obstetrics or surgery.

One plan provides members with a choice of surgeons and other specialists on its approved lists but gives no choice when the member is hospitalized in its own hospitals. The exception, as previously noted, is where the patient's general practitioner hospitalizes her for obstetrics.

One plan, which has a panel of about 100 physicians serving its members on an ambulatory basis in outlying areas, has added some physicians to the panel upon recommendation of its members.

ADEQUACY OF FACILITIES

The appearance, lay-out, and size of the physical facilities visited were, for the most part, satisfactory for the types of service rendered. They were either housed in individual buildings, built to specification or remodeled to meet the plan's needs, or located in office or light-manufacturing buildings one or more floors of which had been remodeled. In some instances, addi-

10. *See p. 22 note 9.*

tional improvements have been made subsequent to the original occupancy of the quarters as utilization increased or new services were offered.

In three plans, total space appeared to be rather limited, with examination and treatment rooms too closely spaced or the size of the rooms somewhat inadequate for their designated purpose. Two other plans were planning to move to new quarters. The facilities in most plans were pleasingly and adequately furnished.

Technical equipment was adequate in most plans, while in some plans it was excessive in amount. One plan appeared to have a minimum of equipment available to perform the services claimed.

CONTINUITY OF CARE

The supervision and management of a case so as to assure the patient of complete continuity of care is an ideal that is sought but not always achieved in any form of medical practice. Since continuity is necessarily relative, its degree and character in any single plan must be compared with what constitutes an acceptable standard in medical practice.

Continuity of care is an important consideration in studying these plans because it affects the quality and quantity of medical care provided. In any appraisal of this continuity, consideration must be given to the scope of services available, the quality of medical care provided, and the financial ability of the patient to pay for services essential to proper treatment. Both advantages and disadvantages with respect to continuity appear to exist in the traditional patient-physician type of practice as well as in the clinic practice conducted by large staffs of physicians. Some direct-service plans maintain that such continuity can be assured only in programs of this type. On the other hand, some physicians see shortcomings in continuity in the services rendered by these programs.

Continuity of care depends on many factors, among which are the office hours available to members, the accessibility of facilities, the number of physicians available on any one day of the week, the number of hours they serve, the waiting periods for various tests and examinations, the administrative procedures for follow-up or return appointments, the coordination of services, and the continuity of management of the individual patient. Continuity also depends upon the patient's willingness to cooperate with his physician's instructions. Some of the plans were developed in order to supplement services the members receive from their private physicians, with no intention to provide complete care.

Virtually all the plans visited by the committee operate all day on weekdays and one-half day on Saturday. Four plans with health centers may be considered to have evening hours, although three are open only until 7 p.m. Nine plans have 24-hour switchboard service to assist members in securing a physician after the center or clinic is closed.

About three-fourths of the plans have facilities which are situated within relatively short distances or traveling times from the members' homes or places of work. Some plans did not appear to have a location reasonably convenient to most members.

Most of the plans visited employ physicians who serve on a part-time basis. They serve two or three hours at a time, and in at least two plans they average between 18 and 20 hours per week. Many physicians work from four to six hours either two or three days a week, generally at a regularly scheduled and mutually agreeable time. Three comprehensive plans employ full-time physicians primarily. In at least four plans, members visit the offices of the physicians on an appointment basis for specialized services, and in one plan most of the "family" physicians see members in their own offices. The number of physicians serving the plan each day and the types of specialties covered is determined by the appointments which have been scheduled and is limited by the number of physicians serving the plan or available to it. Since an average of from 10% to 15% of all appointments are not kept, some plans over-schedule appointments or reserve time for "walk-ins" or emergencies.

A number of plans had a backlog of members to be seen for various types of examinations, particularly elective physical examinations and certain laboratory or x-ray tests. Waiting periods in some plans were as long as three weeks; in others they were somewhat shorter.

Most plans appeared to have a definite routine established in the processing of patients, including the taking of histories, the provision of treatment and of laboratory and x-ray services, referrals to other specialists at the clinic or to the offices of specialist consultants, and arrangements for return visits. The effectiveness of this effort to achieve continuity of care depends upon the plan's success in informing its members of the results of various tests and examinations, and the need for follow-up visits. The success of this effort varies from plan to plan. The medical director of one ambulatory medical care plan remarked that sometimes the loss of continuity between a center and a hospital represents a marked deficiency. The medical director was calling attention to the fact that there is a loss of continuity where outside surgeons or other physicians hospitalize patients who come to the center for ambulatory care. In this connection, the committee noted that continuity may be lost where:

1. Emergencies arise when the center is closed.
2. There is no provision for home calls.
3. There is provision for home calls, but physicians on the staff rotate assignments.

4. Outside physicians are contracted with to make such calls.
5. The center must approve such calls before they are made.
6. The center places restrictions on the number of house calls.
7. Surgeons on the plan staff do not return the management of the case to the individual's "family" physician at the center or in the community.
8. Hospitalized patients are under the care of hospital staffs.
9. Physicians approved by the plan render home calls for which the patient must pay.
10. The center neglects to notify the patient's family physician of the results of examinations and laboratory tests, or of surgery performed by a member of the staff.
11. The physician used as a general practitioner or surgeon is not paid for all his services because some are not approved by the plan.

It was observed that, in one form or another and to some degree, some of these limitations on continuity of care usually exist despite the efforts made by some plans to overcome them. Such efforts are reflected in the coordination of services which a few plans have been successful in attaining; namely, the provision for continuity of consultation, the return of patients to the family physician, and the involvement of the family physician or general practitioner in various aspects of the management of a case.

The plan physicians interviewed felt that, on the whole, they were allotted sufficient time to deal with individual patient problems.

As noted previously, most care is provided in the center at the hours the part-time staff physician is available. In three comprehensive plans, however, full-time physicians are generally available most of the time. In a few instances, the member may visit the doctor in his office. In one ambulatory medical care plan, and in one comprehensive plan, pediatric and obstetrical services of physicians are not available to members.

One comprehensive plan attempts to assure the adequacy of services rendered in one outstanding respect: each of its medical groups contributes 60 cents per member into a special fund which pays for specialist services not provided by the plan.

In one plan, the committee was told by physicians of the preferential treatment of private patients as opposed to plan members.

UTILIZATION OF SERVICES

Information on utilization of the plans' services was made available to the committee by the plans and was supplemented from other published sources. The data from some plans were meager, while in others they were detailed. For some, such data were not available.

Inasmuch as each plan has its own method of recording and compiling data, no strict comparison is possible among all plans or even between any two. Since some count separately each laboratory service on the same day while others count all services rendered on one occasion as one service, the difficulty of assessing certain statistics is apparent. This also applies to the "physician visits" where more than one physician is seen by the member on one occasion.

Utilization of services varies considerably, depending on the age of the members, the location of the plan, its convenience to members, and the amount of educational propaganda used to encourage utilization. It was surprising to note that as few as 15% of the members, and even less in some instances, took advantage of the services of some plans in a one-year period. The maximum utilization reported was 85%.

The diagnostic procedures are also used in varying degrees, depending on the services offered and equipment available. Many plans have ancillary therapeutic services; some emphasize physical examinations; others include eye examinations and prescriptions through their pharmacies. Social services and nutrition services were found in only two plans.

PREVENTIVE MEDICINE

Adequate facilities, as to both personnel and equipment, were available in the great majority of plans visited for the early detection of disease and for the prevention of contagious diseases by the usual immunization programs. Complete histories and physical examinations, routine blood counts, urinalysis, chest x-rays, and blood serologic tests repeated at intervals were the goal in most plans visited. Educational programs of varying intensity and effectiveness were in evidence, representing an effort to encourage members to utilize these services. In some plans multiphasic screening, mass urinalysis surveys, and routine electrocardiograms among members of selected age groups were in progress at the time of the committee's visit. Prenatal care programs followed standard practice in those plans providing obstetrical services. Advice regarding nutrition and social-service problems was available in two plans visited.

Many physicians closely identified with some miscellaneous and unclassified plans placed great emphasis on the important role of these plans in "preventive medicine." The committee gained the impression that there was a tendency by the plans to regard the accessibility of equipment and personnel as insurance to the member against the occurrence of disease. The plans also seemed to foster the concept that they have a particular

value in keeping people well rather than simply in treating them after they become ill. The committee does not minimize the importance of early diagnosis. It is felt that this latter, rather than disease prevention, would be a more accurate claim for any mechanism providing medical service. In summary:

1. The plans visited make standard facilities available for immunization programs and early diagnosis, and they encourage their use.
2. There is nothing peculiar to these plans which prevents the occurrence of disease.
3. Whether efforts in the way of "preventive medicine" are as effective or more or less effective in these plans than in other mechanisms for the provision of medical care is a question to which the committee's observations do not provide an answer. This would require an extremely complicated and searching study which the committee was not in a position to undertake.

RELATIONSHIP OF PAYMENT FOR MEDICAL SERVICES TO TOTAL PLAN INCOME

Neither in its study of 107 plans nor in its visit was the committee interested in a greatly detailed breakdown of income and expenditures; nor did its discussions center about the solvency of the plans. Some data were secured for several of the plans visited, however.

One ambulatory medical care plan with operating costs around $650,000 in 1954 spent 37.1% for medical services in the health center, 13.1% for medical services outside the health center, 9.6% for ancillary medical services, and 30.6% for administrative costs and general purposes. In 1956, costs per eligible member were $18.60 and costs per member served $55.70.

In one ambulatory plan, operating costs in 1955 were over $1,750,000. Costs per eligible member were $8.35 and costs per member served $35.00.

One ambulatory plan's cost of operation in 1955 was $125,000. Physicians' services accounted for 35% of the budget.

One comprehensive plan informed the committee that as of July 1, 1956, 87% of its premiums go to the physicians in its medical groups, 4% toward legal reserves, and 9% for overhead. Total income for the calendar year 1954 was almost $15 million.

Another comprehensive plan estimates that one-third of its total income of $1 million goes to physicians. The lay administrator indicated that 21% of its funds were allocated to hospitalization, 55% to medical expenses (including all professional ancillary services), 9% to administrative costs, 10% to reserve, and 5% to expansion.

RECORD-KEEPING

In the relatively brief amount of time the committee spent visiting each plan, it was possible to review only a small number of records or to glance at others as rounds were being made. The impressions recorded here are general in character, since the actual management of individual cases was not evaluated. On the whole, the records appeared satisfactory, although several marked departures were observed from what might be considered to be "average" records. Lack of legibility is one of the primary weaknesses of such records, but in these plans at least three examples of typed records were observed, making it possible to read and understand the management of the case in a fraction of the time it might otherwise have taken.

One comprehensive plan found that the records maintained in its medical groups revealed various deficiencies. It reported that the work of a special study committee has resulted in the improvement of record-keeping and follow-up procedures.

COMPLAINTS AND COMPLAINT PROCEDURES

In most of the plans visited, the medical administrator received patient complaints from members directly, through the lay administrator, or through employees of the plan. Complaints were then discussed with chiefs of services and/or the individual physicians involved.

The medical director of one comprehensive plan informed the committee that two questionnaires have been sent to his members. Over 90% of those reporting stated that they were pleased with the services rendered. He stated also that "occasional gripes" have been received regarding the length of waiting periods for certain examinations.

One comprehensive plan maintained a subscriber service division which received complaints by telephone, personal visit, or letter. A record has been kept of these complaints and of the physicians involved. A field investigation was reported as begun within 24 hours. Periodically, there has been a review of each medical group's performance, and the performance of the individual physicians. The medical director of the plan has reported that complaints about the individual physician usually stemmed from the fact that he treated his patients as charity cases, that he had not given his patients sufficient time, that he had been "superficial" in his approach, or that he had been reluctant to make house calls. The committee was informed that such physicians have been advised to correct these causes for complaints or be dropped by their groups. The committee was also informed that persons in higher levels of education tend to register more complaints and that nonwhites complain less than do whites.

Another official of the same plan told the committee that the administrative headquarters has received one complaint for every 1,800 services. He felt that the ratio might be high, in view of the 2.4 million services ren-

dered to 426,210 enrollees in 1955. Evidently the number of complaints was approximately 1,300 during 1955, with the ratio of complaints to enrollees approximately 1 to 300.

A study of membership attitudes in another comprehensive plan, the committee was told, revealed that 65% of those interviewed expressed unqualified approval of the plan, 21% were satisfied but had criticisms, 7% expressed "marked dislike" of the plan, and another 7% had no opinion.

In some of the communities of all the plans visited, liaison committees have been established by medical societies to keep abreast of developments and to provide guidance and grievance mechanisms where requested. By the nature of the direct-service plans, complaints regarding the professional activities of physicians serving the plan are not brought to the attention of the medical societies.

One plan which provided medical and surgical care on a specialist level and which originally compensated physicians on a fee-for-service basis with free choice of physician retained, had numerous complaints regarding the activities of a small proportion of the physicians. These were referred to special liaison committees by medical representatives of the plan in many areas where it operates. In some areas these complaints appear to have been handled on a mutually satisfactory basis. In one area, the local society, upon request presented to the plan a list of physician members who were, in its opinion, qualified to perform surgery. In other areas offending physicians have not been disciplined because the medical society committee either lacked the power, was unwilling to accept the responsibility, or did not consider the complaints valid.

Where functioning medical society liaison committees are in existence, complaints are brought to their attention; where relationships between the plan representatives and the society are not clearly defined, or are not effective, the area medical administrator might drop the physician or the hospital from his "approved" list without consulting the society. This has led to the development of rather turbulent situations, since medical societies have taken the position that no third-party mechanism should take upon itself the prerogative of judging the quality of medical care provided by physicians.

OCCUPATIONS AND INCOME OF MEMBERS

There was a wide range of occupation and income among beneficiaries of the plans visited. The low-income, unskilled or semi-skilled employee was typical in about three-quarters of the plans. These and other plans also had members whose incomes place them in the medium and higher income groups. For example, the average income of the members of one ambulatory plan was $2,000, but a small group earned over $5,000. The members work in the women's garment industry.

One ambulatory plan said its members ranged from busboys earning $27 a week to waiters whose weekly base pay was $40. The plan also includes semi-skilled and skilled workers whose incomes are considerably higher. One diagnostic plan had journeymen electricians whose earnings ranged from $100 to $200 per week. The average weekly wage of unskilled and semi-skilled garment workers in one ambulatory plan was between $35 and $40; 85%-90% of the union members are women. The laborers in one ambulatory plan averaged between $3,000 and $4,000 per year. The members of one diagnostic ambulatory ophthalmological plan came from 85 different unions and represented low and middle income groups.

In the two other ambulatory plans, the income was around $2,500 to $3,000 for unskilled workers. In one nationwide plan, members' incomes varied according to local conditions; in some states the average income was between $3,000 and $4,000, in others, between $5,000 and $6,000. The average earnings of the unskilled and semi-skilled members in one comprehensive plan were under $3,000 per year. In one comprehensive plan, 96% of the 15,000 members earned under $6,000. Their occupations ranged from unskilled to skilled.

In one comprehensive plan, enrollment in medical groups ranges from unskilled to skilled and professional employees; incomes vary accordingly. Although the average income was not given, the plan's premiums are based on income limits of $5,000 (individual) and $6,500 (family). About 5% of the enrollees earn more than the limit, but they are charged higher premiums. The committee was informed by some plan physicians that opinion within the plan is divided on the question of raising this maximum or removing it completely. The medical groups visited by the committee contained what appeared to be a cross-section of the plan's enrollment by occupation and income.

The enrollment in another comprehensive plan consisted mainly of government employees whose average family income in 1953 was $7,800.

Two comprehensive plans enrolled employees of the railroad industry. One comprehensive plan enrolled members in three distinct groups: one for students of a university, one for faculty members and their dependents, and one for aged members of a fraternal order. Two plans appeared to enroll a cross-section of community incomes and occupations.

LITERATURE, PROMOTIONAL METHODS, AND ADVERTISING

In its visits, the committee inquired into the methods employed by the plans to acquaint their members and

others with the purposes and benefits of the plans. Various types of literature and promotional materials were assembled.

Plans which provide medical services to specific groups distribute literature by mail, at union or other group meetings, at special meetings conducted by shop stewards, or at educational meetings conducted by representatives of the plan itself. Various publications are also utilized to acquaint members with the existence, operation, and benefits of particular plans.

Plans enrolling new members employed some of the foregoing techniques and, in addition, some have employees who solicit groups directly or through group representatives. Such groups may be occupants of housing projects or members of community organizations.

At least two comprehensive plans employed representatives to inform prospective groups of the provisions of their plans as well as of competing plans. On this basis, the prospective group is asked to make its choice of the plan it desires.

After enrollment, members of some plans receive special publications concerning the finances of the plan, benefits, data on utilization, and health information which includes guides and suggestions for the maintenance of health. Some of these publications included various types of comments emphasizing the value of the particular plan's services over those otherwise provided. A few of the plans distribute to members lists of physicians affiliated with the plans.

The committee was informed that advertising in newspapers had been utilized by certain plans on a few occasions in the past years. One plan had run an advertisement which, the committee was told, was similar to that used by the local Blue Shield plan. The committee was informed that this plan has discontinued its advertising.

One medical director told the committee that the local medical society had, at one time, raised objections to the contents of certain leaflets and brochures issued by his plan. He had informed the medical society that this material had been prepared by the lay administrator without his knowledge or approval. He also told the committee that he had subsequently assumed authority and responsibility for all literature, and that he has had no further complaint in this regard from the medical society.

ATTITUDES OF MEDICAL SOCIETIES TOWARD PLANS

It has not been considered necessary to present an exhaustive historical review of medical society attitudes toward the plans being studied by this committee. It can be pointed out that approval and disapproval, acceptance and lack of acceptance, cooperation and lack of cooperation, have existed almost side by side for plans of a similar nature at various times and in various parts of the country. There appears to have been relatively free acceptance of many management-sponsored plans by physicians, but acceptance of plans sponsored by unions or consumers has been somewhat reluctant. The committee's discussions with 89 representatives of various local and state societies reflect the various attitudes and opinions generally expressed.

In one meeting at which several county societies were represented, it was pointed out that one society had given its formal approval to diagnostic and ambulatory health centers. The chairman of that society's committee told the Commission that the union members of those plans were getting better care than they received before the centers were available. The officer of another county society indicated, however, that union health centers do not render medical care as good as that rendered by private medical practice. The chairman of the county medical society committee approving the health centers expressed his opinion that many plan physicians were not being compensated adequately for their services. Another criticism voiced against union health centers was that they do not provide physicians with sufficient opportunity to determine medical policy. Expressions by physicians interviewed seemed to favor diagnostic services provided in these centers, but questioned the extent to which preventive medical care was being practiced.

The criticisms of a comprehensive plan in that city centered around "lack of free choice of physician" and "the practice of clinic medicine which might lead to a deterioration in quality of medical care." There were complaints that a plan of this type, in soliciting members, was in effect obtaining members for affiliated medical groups.

At the inception of the plan, the county socieites were invited to designate members to serve on the plan's medical control board. At first, some county societies appointed representatives, but such representation was subsequently discontinued by the societies because of some of the objections cited above, and no official contact is now being maintained between medical societies and the plan.

In another large city, the officials and other physicians of a county and state medical society made a number of observations about union and management health centers. Among the opinions expressed were the following:

1. Since these plans are in widspread operation, there would appear to be reason for their existence; the answer is to compete with them.
2. Medical services rendered by these plans are good; physicians were qualified, felt adequately paid, and were not overworked.

3. The medical profession can best compete with the development of these plans by offering service contracts to labor and management, thus preserving the role of private practice. One physician stated that "some persons think they want comprehensive benefits through closed panels, but are disappointed to find that they do not get the personalized care they desire."
4. The quality of medical care does not equal that possible in private practice.
5. If labor wants to set these plans up, and if its members are satisfied with the quality of medical care provided, they are welcome to it.

In addition, some questions were raised by physicians regarding lay administrative limitations on medication and treatment.

The general consensus of some private practitioners seemed to be that the physicians serving the plans in that city were well qualified and enjoyed their work. Social consciousness and a desire for financial security were two reasons why physicians join those plans, the committee was told.

In another city, the committee met with those members of the county medical society whose society activities concerned union health centers. Among the thoughts expressed were the following:

1. These plans are here to stay and should be encouraged by the medical society to provide good-quality medical care.
2. At least one-third of the governing board in all plans should be composed of physicians.
3. Many patients do not prefer the health center but go there for certain laboratory tests which are costly if done elsewhere.
4. Health centers have cooperated with physicians in private practice in performing laboratory tests; cooperation thereby between the health center and the medical society will benefit the society and the general practitioner.
5. Centers are not affecting the private practice of medicine, but if they were to spread they might change existing medical practice.
6. The disturbing element is the trend from diagnosis to comprehensive care.
7. Statements about "low" family income are not accurate if the total income of all household members is taken into consideration.

Although most of the physicians felt that these centers should be given proper guidance and direction, one of them described these centers as "compulsory medicine." He stated that the centers with their closed panels are established and financed by agreement between management and the unions, and are subsidized by the employees even though they might not wish to utilize the plans. Consequently, this physician argued, the individual must utilize the plans or forego some of his compensation. The financing of these plans by management can, in effect, be considered part of the wages the individual might have received if these fringe benefits were not agreed upon. He stated that the centers were not destined to remain in existence, and that medical societies should oppose them or "face the consequences." He believes that physicians participating in health centers are not conducting themselves ethically with respect to choice of physician.

In another city, the committe was informed that there was at present no friction between the society and a comprehensive plan, as had previously existed. In fact, the medical director was currently active on one important medical society committee. The society had interviewed every member of the staff of this comprehensive plan and had found that the physicians were all satisfied with the plan and that they experienced no interference with their work. The medical society felt that the staff of the comprehensive plan was reliable and qualified, and that the clinic was conducted in a satisfactory manner. However, the members of this plan also utilize physicians not associated with the plan, indicating some degree of dissatisfaction with one or more elements of the plan. One of the society's objections to this plan when it was first started was that a government agency had subsidized it.

With regard to another plan, the society had been approached by the union several years ago asking for advice in formulating a program to be instituted. The society had spent almost a year working out the details. A fee-for-service program provided through a group-practice center and through other community facilities and personnel resulted from the society's work. The society maintains liaison with the health center and is satisfied with its operations and with the patient care provided. The society had withdrawn its approval for a brief period in the past when it appeared that the plan was not carrying out its recommendations, but approval was restored when the plan returned to the original agreement. The members of the society have been asked by the union to help educate the plan's members to utilize its services, for which money was accumulating in a trust fund, instead of going to dispensaries as indigents. The society is satisfied with the plan, which provides union members with a choice of facility and some choice of physician, and it realizes that it has worked out a satisfactory solution to a problem for which it had no precedent.

In one area, the committe was informed that physicians working for various closed-panel plans appeared to be well qualified and were performing good work; that the quality of medical care rendered to patients was good, that hospital care provided was good, and that there was no evidence of lay domination. There

was some criticism of the out-patient services rendered by one plan, but this criticism would also be applicable to services provided by some other hospitals in the community. There was also some feeling that physicians in one plan were overworked, that waiting periods were too long, and that physicians were distracted by the turnover of patients. Several members of the medical societies stated that closed-panel plans were here to stay and that the medical profession should develop plans which would compete with closed panels and thereby prove that free choice results in better medicine.

It was asserted that there was no choice of physician in one plan, although the plan maintained that such choice existed. The committee was informed that one closed-panel plan which had been in existence for many years had not met with the same criticism that a more recently established plan had. With respect to some of the ethical problems involved, sharp criticism was voiced against the practice of industry and insurance companies in the treatment of occupational-disability cases. Criticism was also made about certain hiring practices of the Veterans Administration.

The committee was told that many members of one plan use its services as a sort of catastrophe insurance, but go to their personal physicians for regular medical care. One physician expressed the opinion that to many patients the concept of free choice of physician is archaic, and that many people are more interested in securing broader medical care than in selecting their own physician. The opinion was expressed that one plan, which had aroused considerable concern in several communities, was limited in its future growth by the facilities available, and that at present it did not have the finances to expand greatly. It was also stated that the medical society prepaid plan would eventually win out over one particular closed-panel plan since it was competing with that plan and offering the choice of physician which people want. In several areas, initial reluctance to accept physicians of one plan into society membership is gradually being overcome, and greater numbers of these physicians are being accepted on their individual merits.

In another area, criticism of one plan centered around its lack of continuity of services and the inadequate number of physicians to take care of patients' needs. There was also some criticism of the method employed in the past to encourage physicians to qualify for a bonus. It was also stated that one plan cancels group contracts if the group has a poor experience rating. The institution of a system of dual choice of plan by individual members of groups has been a positive step by this plan, although there was some question as to the procedures followed in offering the choice. It was felt that other prepaid groups are doing a poor job of selling their programs to compete with the closed-panel plan in question. The opinion was expressed that the closed-panel has been more successful in attracting lower income groups than have competing prepaid plans.

The major criticisms concerning one closed-panel plan appeared to be that it still had "captive" patients, that it resulted in loss of the patient-physician relationship, that in some cases the plan physicians' relationships with patients had the effect of creating poor public relations for the medical profession in general, that it was sometimes using ancillary personnel incorrectly, that patients had to wait too long for services, and that the plan posed an economic threat to physicians in smaller communities. It was stated, however, that the presence of this plan appeared to result in more satisfactory services and charges by physicians in the community.

It was pointed out to the committee that fairly recently in one area many practicing physicians have been accepting fee schedules in full payment for medical and surgical services for members of various union groups. It was estimated that perhaps 50% of the physicians in the community are engaged in this practice, which appears to be an important development in medical care on a fee-for-service basis. This was considered significant since, in this manner, unions are now able to secure full payment for their members without joining the closed-panel plans in that area.

The meetings with representatives of several county medical societies and one state medical association were devoted primarily to a discussion of developments and problems with respect to another union plan. This plan, with the largest membership of all plans in the country, has been described in the preceding pages as the one with some 6,800 "approved" physicians providing in-hospital and office care on a specialist level on either a fee-for-service or retainer basis. The physicians on the plan's hospital staffs are on salary. The physicians on retainers are referred to as those on "preferred" lists.

The committee heard various expressions of opinion with regard to this plan. There was seldom unanimity regarding any statement made. The adverse opinions expressed by individual physicians to this particular plan in the one area visited are reflected in the following comments:

1. Things seem to be run from Washington.
2. Physicians are taken off the approved lists without consultation with the medical society.
3. Some individuals within the plan have stirred up feelings in the community at times by inaccurate and misleading statements.
4. Some fear there is an over-all plan to remove proprietary hospitals from approved lists, so that beneficiaries will be forced to go to the plan's hospitals.
5. The fact that the names of the physicians on retainer

are not known is resented, rather than the fact that these physicians have this financial arrangement.

6. Certain physicians (those on preferred lists) have privileges not accorded to other physicians, such as prescribing drugs without prior approval of administrators.
7. There is a fear that plans of this type might lead to channelling patients to physicians on preferred lists.
8. Plan hospitals have taken nurses away from other hospitals by offering higher salaries.
9. The union controls the hiring and dismissal of "check-off" doctors.
10. The plan removes hospitals from approved lists without apparent justification.
11. The plan's hospitals admit private patients who can pay the established flat rate when beds are available, and therefore compete with other hospitals and their staffs.
12. The plan's hospitals make no provision for the care of indigent patients, since the plan is established for the care of its beneficiaries.
13. Statements which attempt to justify the establishment of plan hospitals on grounds other than the need for additional beds have resulted in serious differences of opinion between the societies and the plan.
14. The plan has fallen down where it is needed most by cutting off medical care to widows and orphans one year after the death of the worker.
15. General practitioners are approved in some places but not in others.
16. The plan often generalizes in its criticism against the profession in a given area rather than substantiating charges against specific individuals.
17. Certain area medical administrators are difficult to work with.

The favorable attitudes and opinions expressed by individual physicians concerning this particular plan in the one area visited are reflected in the following comments:

1. In one area, the problem of specialist designation by the plan does not exist. In this area the local medical society has listed qualified surgeons, and the plan has accepted this list.
2. The staff of the plan's local hospital does a good work-up.
3. The attitude of the society as a whole is one of tolerance.
4. The society's liaison committe works well with the area medical administrator.
5. The selection of specialists is a medical society responsibility, and is aided by hospital staff knowledge of each physician's experience and previous record of performance.
6. The plan has been of help because now physicians are being paid for work which they formerly performed for little or nothing.
7. The number of hospital beds has increased.
8. Health education is being furthered.

In one community the committee was informed that the plan does not use a definite fee schedule (it will pay whatever charges is considers "reasonable," and, therefore, "the basic concept of good medical care at a reasonable fee as promulgated by the plan is valid"), that patients have free choice of physician and hospital, that the plan does not channel patients, that a physician has a right to accept the method of remuneration he wants, and that the medical profession should encourage the development of Blue Shield plans as an alternative. Another physician remarked that there is a need for an upward revision of local Blue Shield fee schedules because they are too low and are being used by the plan as criteria for average fees.

It was apparent in one area that the personality of the plan's representative, his willingness to work out problems with the society, his understanding of local problems, and his interest in seeking practical solutions have made the plan acceptable to physicians generally —even with its limitations as expressed by certain physicians. A wholesome example of the relationship between the plan's area representative and the medical societies is illustrated by the fact that both he and the medical director of the local plan hospital were invited to the meeting of medical society representatives at which these comments were made. The plan's area medical administrator agreed with some of the remarks made and disagreed with others, while giving his assurance that some of the fears stated were without foundation. Both the plan and the medical societies' representatives expressed mutual willingness to resolve problems as they arise.

Although the committe visited only one state in which this plan operates, information on developments in other states and attitudes of other county and state societies were conveyed to it by the chairman of the A.M.A. Committee on Medical Care for Industrial Workers. During the two weeks before its meeting with the members of the Commission, this A.M.A. committee had met with representatives of the states in which acute problems had arisen in relationships with the plan.

In one state, an agreement[11] between the plan and the state society had been abrogated by the latter's House of Delegates despite certain safeguards in the agreement to forestall action of this kind. The action was taken, the committee was told, at the behest of several physicians in an area where the plan had re-

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11. *"Agreement Between Miners Fund and Pennsylvania Medical Society" (Council on Medical Service), J.A.M.A. 161:164-165 (May 12) 1956. Cf. "Agreement Between UMWA Welfare and Retirement Fund and Medical Society of State of Pennsylvania" (Editorial and Comments), ibid., p. 155.*

moved a hospital from its approved list. The House of Delegates of that society then appointed committees to define fee-for-service payments and their exceptions and to draft principles governing physicians' relationships with all third-party groups.

Two other state societies have passed resolutions dealing with two of the issues previously discussed: free choice of physician and method of remuneration. Both have informed physicians that they did not look with favor upon any physician who includes the plan in his negotiations with its beneficiaries.

The attitudes and actions of the one state society visited and the three state societies mentioned by the chairman of the Committee on Medical Care for Industrial Workers seem to represent the range of attitudes and opinions about the plan under discussion. The issues and problems are not new; they have existed ever since the plan's medical program was instituted. Some of the problems have been resolved to the mutual satisfaction of the local medical profession and the plan; others have merely simmered over the years and erupted when certain stimuli appeared.[12]

It can be seen from the foregoing that the opinions expressed by representatives of the medical societies concerning various forms of medical care plans are varied and far from unanimous.

ATTITUDES OF SPONSORS, MEMBERS, AND PARTICIPATING PHYSICIANS

The preceding section contained a summary of the attitudes of medical societies toward these various plans. The committee has assembled in this section the most commonly stated views of persons directly associated with various plans, particularly closed-panel plans. The fact that these points of view are set forth here does not necessarily imply that the committee agrees with them. The comments are based on statements in pertinent literature and on spontaneous comments volunteered by sponsors, by physicians participating in plans and, in some instances, by members. This section does not purport to contain a complete review of all the comments, reasons, and motivations.

Sponsors

Various reasons have been given for the organization of the prepaid medical care plans studied by this committee. Some of the plans were organized by fraternal groups to furnish medical care for their members. Some were formed by management in order to provide medical care in areas where care was not available. Unions, management, and other groups have developed plans in some instances because of a real or presumed lack of adequate facilities and personnel to provide the type and quality of care desired, or in an effort to reduce costs of medical care, particularly of diagnostic and laboratory services. They may believe that members or employees need more and better care than they were previously receiving, and at lower cost.

Some unions believe that by organizing such plans they encourage a closer relationship between the member and the union. They emphasize to members the advantages of collective bargaining for medical, surgical, and hospital benefits. Management believes that these plans bring about a closer relationship between the employee and the employer, result in a more stabilized work force, and reduce production losses.

The benefits of these plans range from ambulatory to comprehensive medical care and are provided by closed panels or by physicians on a free-choice, fee-for-service basis. Various combinations of these methods are also used. The union, management, or consumer groups organizing plans indicate that the scope and objectives and the methods by which service is provided are determined by the needs of the members. Many of these groups believe that the closed-panel practice of medicine is the best means of providing good medical care at low cost. Their argument against free choice of physician is, in part, that the average person does not have unlimited free choice of physician anyway because his selection is limited by his ability to pay, by information or lack of information as to the skills of the physicians in his community, by the number of physicians available, and by other factors. They also argue that free choice of physician does not mean that the patient will select and obtain the best medical care. Some assert that, in some instances, patients who selected their own physicians obtained inferior care.

The sponsors of these plans believe that their over-all effect on medical care has been beneficial and worthwhile if present conditions are compared with those existing prior to the development of the plans. There are programs to expand the scope of existing plans and to establish new ones in other areas, if they are warranted and if funds are available. They believe that these plans have stimulated development of other types of medical care plans sponsored by other groups, including members of the medical profession and commercial insurance companies.

Members

Persons desire to participate in these plans for various reasons. Some do so because they fear they may not be able to pay for the cost of medical care when needed, either for themselves or for their dependents, and because they believe that these plans would cover more of the total cost of medical care than would other plans available to them. In addition, the individual may not have to pay the cost of participation directly, for it is

12. *In June, 1957, the A.M.A. House of Delegates adopted the above-mentioned "Suggested Guides" (p. 21 n. 8), which the executive medical officer of the Fund has since declared are unacceptable.*

often paid indirectly, either in whole or in part, by the employer.

The availability of dental care, physiotherapy, laboratory services, and other "extras" as part of the plan attracts some persons. Some believe that if they belong to a particular plan a physician will be more readily available than otherwise. Some persons, previously charity patients, may look upon a prepaid plan as a means of paying their own way. Others may be interested because they are members of a fraternal, union, or labor group which has developed a plan and, therefore, they feel they should use it.

Changing social philosophies have also resulted in increased support for these plans, as has the desire among the general public for continued improvement in methods of financing and provision of medical care. Some individuals, particularly those who have never experienced a patient-physician relationship, do not attach much importance to that relationship in selecting a plan for themselves. The patient-physician relationship is changed for those who become members of a closed-panel plan as a result of a group decision which they did not favor, and for those who had a family physician before joining such a plan.

After having participated in the plan, the majority of the members of certain plans approve of the method of operation. Low-income groups indicate that these plans fill a definite need; that is, they enable members to obtain medical services which the members believe they otherwise might not be able to afford. Some believe that they are getting good care even though they indicate dissatisfaction with relationships with the staff physicians, waiting periods, hours of service, poor location of facilities, and other matters. They believe, however, that these factors are counterbalanced by other factors mentioned previously, which they deem advantages of this type of plan.

Utilization in some plans appears to be lower than anticipated. Some members of a plan continue to use personal physicians. Others might prefer to use their own personal physicians but are reluctant to pay the cost of a service which is also available through physicians provided by a plan which they may be supporting indirectly through payments by management as a result of collective bargaining. Some members would, of course, like to see benefits expanded. Many believe that better medical care at a minimum cost is the objective of all these programs, regardless of the nature of the benefits or the method by which the benefits are provided. When members of a direct-service plan express their satisfaction with it, others may be led to believe that these plans are to be preferred. Conversely, member dissatisfaction with the character of medical care provided, with the relationship with the plan physicians, or with other factors may discourage utilization by members and influence others not to join.

Participating Physicians

Physicians providing medical service for these prepaid plans gave varied reasons for becoming affiliated with them. Some desired part-time employment as a means of supplementing income. Young physicians in particular wanted a basic guaranteed income while developing a practice of their own. Some physicians stated that contacts at the plan enabled them to develop a practice by direct contact with patients or by referral. Many physicians stated they were interested in working at clinics because of the wealth of clinical material available for their education and experience. Others, particularly those on a full-time basis, were attracted because they were expected to work only a definite number of hours and because retirement benefits and other fringe benefits were provided by some plans.

Many physicians indicated that they became interested because the physicians practiced as a group. They desired group practice because of the close professional associations which they believe this type of practice offers, and they believe that in such an environment they can utilize their skills to a greater degree. Some have a sense of dedication and indicate that they are gratified to provide medical care to individuals in the low income groups served by many of these plans.

Most of the physicians associated with these plans believe that the medical care rendered by plan physicians is good. These physicians feel they have been providing the same quality care which they would render to patients in private practice, and that the availability of equipment and ancillary services tends to raise both the general level of medical care and the level of care available to specific individuals. They point out that they can order diagnostic procedures and provide treatment and medication without having to consider or discuss with the patient the latter's ability or willingness to pay for the services. Further, they can, to a large degree, ignore the business responsibilities of a medical practice and concentrate on their professional work. Some of these physicians stated that, although preventive medicine is an ideal and a major objective of these plans, it constitutes a very small portion of the activities of most plans. Some also indicated that the power of lay boards of trustees and lay administrators in these plans could result in lay domination of medical practice, in exploitation of physicians, and in medical care inferior to that of private practice.

II. STATEMENT CONCERNING LAWS RELATING TO MISCELLANEOUS TYPE PLANS

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INTRODUCTION

In the course of its work, the committee learned that many varied laws were important in considering the organization and operation of the miscellaneous plans and the relationship of medical societies with these plans.[13] The committee believed that a statement regarding these laws should be included in this report for the information of the profession. The statement which follows is written for physicians, not lawyers. It avoids technical legal terms and detailed analysis and discussion of statutes and decisions. For clarity and brevity, no cases are cited in the text. A few are referred to in the footnotes by way of example.

The statement is divided into three parts. The first part, pages 34-37, shows that the law applicable to the organization of the miscellaneous plans varies from state to state and that closed-panel prepaid plans are legal in some states even though a corporation is involved and the plan engages in advertising. The second part, pages 37-42, shows that medical societies may adopt standards for members, but that by taking action against physicians because they render services for prepaid plans, including closed-panel plans, they may, in certain circumstances, violate federal or state laws relating to restraints of trade. The third part, page 42, shows that the A.M.A. is a federation of state medical associations. State associations and county and district medical societies have considerable autonomy. They may and do act independently of the A.M.A.

13. The miscellaneous plans are defined on page 12 of the committee's report. Most but not all of these plans are closed-panel plans. A "closed-panel" plan is also defined on page 12 of the committee's report. In general it is used here to describe a plan in which a limited number of physicians selected by the plan render the medical service.

I. LAWS RELATING TO THE ORGANIZATION AND OPERATION OF PREPAID PLANS

The legal status, internal organization, and operation of prepaid plans are in the main governed by the laws of the states in which the plans are organized and operated. These laws and the structure of the plans vary from state to state and within the states, so that a detailed statement of all applicable law would be impracticable. The purpose of this section is twofold: to show that as a result of court decisions in some states, legislation, and the changes in social philosophy which have occurred in this country, these miscellaneous prepaid plans, particularly closed-panel plans, can now be legally organized and operated in some states; and to illustrate the variety of laws under which these plans are organized and operated.

The often-repeated phrase "corporate practice of medicine" is used by many to describe not only many prepaid plans but also other different arrangements by which corporations make medical services available to a well-defined group or to the general public through arrangements with physicians.[14] Some use the phrase to refer to one of these types of arrangements but not to others. Others, however, even use the phrase to describe an arrangement in which the organization providing or agreeing to provide the service is not a corporation but a partnership, unincorporated association, or trust. As applied to these plans, the 'phrase' "*corporate* practice of medicine" is a misnomer. Since this phrase has many different meanings and can be misleading, it will not be used again in this statement.

The law applicable to the legality of the organization of prepaid medical plans is found in court decisions and legislation which vary from state to state. Because of the nature of most of the plans reviewed by the committee, the discussion of these cases and legislation in the pages that follow is concerned primarily with corporations which provide, by one method or another, prepaid medical services performed by a limited number of physicians selected by the corporation—a closed-panel plan. Closed-panel plans and other miscellaneous plans operated by trusts and by other arrangements will be considered separately.

A. Court Decisions Relating to Corporations which Utilize Closed Panels

In the absence of legislation authorizing it, most courts have held illegal the sale by a corporation of medical services to be rendered by physicians employed by the corporation, payment being made to the corporation either before or after the services are rendered. The decisions are based on various reasons. One very common statement in the decisions is that a license to practice medicine requires certain personal qualifications and training which cannot be met by a corporation, since a corporation is inanimate. Other courts reject this reason as being superficial but reach the same result because they believe that the sale of medical services by a corporation would tend to commercialize the profession and that there is a danger medical standards would be debased. Some courts have emphasized divided loyalty and impaired confidence. They believe that the physician would be torn between loyalty to his patient and loyalty to his employer and that the threat of interference by laymen in medical matters is ever-present.

There is, of course, no constitutional provision or other inexorable principle which prevents a state from authorizing a corporation to provide medical care. The question is one of state public policy determined by the legislature or by the courts in construing state law. State policy in this respect may be, and has been, changed by both the legislatures and court decisions.

Some courts have held that public policy does not prohibit the operation of a closed-panel plan by a corporation organized not-for-profit and have held these corporations lawful even when organized and controlled by laymen. These courts believed that the evils and dangers referred to above do not exist in a nonprofit organization to the same extent as they do in a profit corporation. One of these decisions, at least, appears to have overruled the state policy as expressed in an earlier decision of the same court. Some courts make a distinction between the practice of medicine and the administration of a plan in collecting money, making contracts, and the like. The latter functions do not require a license to practice medicine. Some courts have indicated a distinction between those plans owned and operated by physicians and those by laymen.

Illustrative of this philosophy, a court in one case held that the reasons advanced for prohibiting the purveyance of medical care by a corporation did not apply to a not-for-profit corporation organized for the mutual benefit of members who were employees of the government to provide medical services to these members through a closed panel of physicians under contract

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14. Among arrangements by which corporations make medical services available to a well-defined group or to the general public through arrangements with physicians are the following:

Corporations organized for profit by laymen to sell contracts for medical services to be rendered by physicians who contract with corporations to do so;

Railroads, mining and lumber companies, and other industrial organizations which provide medical services to their own employees by physicians who contract with the organization to do so;

Fraternal and mutual benefit organizations which provide medical services to members through "lodge" physicians;

Hospitals and medical schools which provide medical services through physicians under contract to do so;

Cooperatives organized by lay groups to provide medical services to members on a non-profit basis through a limited number of physicians who contract to do so;

Not for profit corporations organized by laymen to contract with the general public to provide medical service which is rendered by physicians contracting with the corporation to do so; and

Union health centers or other plans financed from a pension and welfare fund or collective bargaining and using a limited number of physicians.

with the corporation.[15] In another case the court held lawful a corporation organized by a layman under the state's general not-for-profit corporation act which, through the membership device, sold to the public medical care provided by a closed panel. Extensive advertising and solicitation were used to sell contracts.[16]

B. Legislation Relating to Corporations which Utilize Closed Panels

The legislatures of a number of states have expressed the state policy or changed it by enacting laws or by granting special charters which permit the organization and operation of plans which otherwise might have been subject to serious legal questions under the court decisions which prohibited certain corporations from providing medical care. The method used by the legislature differs from state to state and sometimes within the same state as to different types of plans. Some of the plans visited or studied by the committee have been organized under general statutes enacted by state legislatures to enable the establishment of plans of a particular type in accordance with the procedures and requirements outlined in the statute. In at least one instance the legislation, although in general terms, is suited to the needs of only one particular plan. In other instances plans have obtained special charters from the state legislature in order to provide medical service. The special charter, which is applicable only to the plan in question, authorizes the organization and operation of the plan in a specified manner. In a few instances plans have been organized in whole or in part under the general law of the state authorizing the incorporation of "not-for-profit corporations." Special legislation was not necessary. In at least one state a court decree approving the purposes of the corporation must first be obtained.

Lay sponsors of medical care plans have sometimes sought and obtained this legislation. They have done so for various reasons, such as to resolve legal questions raised by the decisions referred to previously concerning corporations, by existing insurance laws, and by possible questions of fee-splitting, advertising, and soliciting, and also to obtain legislative approval of internal arrangements which the sponsors felt were needed to achieve the purposes of the plan.

Varied state laws also govern the internal structure and operation of the plans after their organization. If organized under general not-for-profit corporation statutes, the detailed provisions of those statutes apply. Some special statutes which enable closed-panel plans to be organized also impose specific requirements concerning their internal structure and operation. These laws also vary from state to state. Some laws have specific provisions regarding the composition of the governing board. In other states there are no statutes on this subject. In some states medical representation on the board is not required. In others medical representation is required. One of the states requires that 30% of the members of the governing board of a particular type of plan shall be physicians and that the medical director may participate in the deliberations of the board but without the right to vote.

There are variations from state to state with respect to supervision by state officials of the finances and method of operation. The extent of supervision of finances not only varies from state to state but may vary within the state with respect to different types of plans. In other states, for all practical purposes, there is no supervision. In some areas health centers or clinics are subject to inspection by health authorities.

C. Partnerships, Unincorporated Associations, and Trusts

As mentioned at the outset of this section, partnerships, unincorporated associations, and trusts have been used to operate prepaid plans. These and other devices, rather than corporations, have unquestionably been utilized in some instances to avoid challenge under the court decisions referred to previously concerning corporations. The structure and method of operation of these devices may vary to an even greater extent than the plans operated in corporate form.

As is the case with corporations, the legality of these devices, particularly arrangements with physicians to provide medical services, depends primarily on applicable state law but might be even more difficult to determine. The precise arrangements, contractual or otherwise, between the partnership, association, or trust, the physician, and the subscriber, would have to be known in order to determine the legality of such arrangements, and an extensive analysis would have to be made of the relevant statutes of the particular state, including statutes dealing with the practice of medicine, partnerships, associations, trusts, insurance, and the like, and of any court decisions relating to these subjects.

In some instances corporations, clinics, trusts, partnerships, and other arrangements have been used for different functions or aspects of the same general plan. For example, one corporation or organization may contract with subscribers; another may be used to acquire property which is then leased to another corporation or to physicians; a corporation may be used to own and operate hospitals, this corporation, in turn, being paid for its services by the organization having contracts with subscribers; one of the corporations may contract

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15. Group Health Ass'n. v. Moore, 24 F. Supp. 445 (D.D.C. 1938), affirmed sub. nom., Jordan v. Group Health Ass'n., 107 F. 2d 239 (C.A. D.C. 1939).

16. Complete Service Bureau v. San Diego County Medical Society, 43 Cal. 2d 201, 272 P. 2d 497 (1954) reh. den.

with a partnership of physicians or hire them to provide services. Various other combinations have also been used and may be possible. The law of the state in which the plan is organized and operated influences to a large extent the legal form the plan will use.

D. The Taft-Hartley Act

To some extent the legal form is also influenced by the provisions of the federal Labor Management Relations Act of 1947, commonly known as the Taft-Hartley Act. Payments for prepaid medical care are, in large part, obtained through collective bargaining, which is subject to the provisions of that Act. The Taft-Hartley Act expressly permits payments to be made by employers, through collective bargaining to trusts established by employee representatives for the benefit of the employees and their families and dependents. Many trusts of this type have been established. The money paid into the trust can be and is used, to provide, or buy insurance for, medical and hospital care among other purposes. These trusts provide for medical care through direct private insurance carriers, lay-sponsored plans, physician-sponsored plans including Blue Shield, separate corporations established for the purpose, direct payments by the trusts, health centers, and other means. The Taft-Hartley law neither prohibits nor requires medical representation on the governing board of the trust. Some states have enacted laws with respect to pension and welfare trusts.

SUMMARY

Thus, unwisely or not, state laws do not universally prohibit a corporation from utilizing a closed panel in the operation of a prepaid plan. Unquestionably, in the absence of permissive legislation this practice in some form is barred in some states. It is clearly lawful in other states when conducted by not-for-profit corporations organized under corporation statutes or enabling legislation. Between the two extremes, in other states, these closed-panel plans are lawful in varying degrees and forms. Similar variations are found with respect to internal structure and operation. Some plans are operated by partnerships, unincorporated associations, and trusts. In case any question should arise as to the legal authority of any plan, the problem should be reviewed by a lawyer familiar with local law for a careful analysis of the statutes and the decisional law of the state in which the plan is incorporated or formed or in which it is operated, or both.

II. ANTITRUST LAWS RELATING TO MEDICAL SOCIETIES AND PLANS

The statement is often made that a membership association may grant or deny membership for any reason it sees fit and may discipline members for the purpose of enforcing conformity with the association's policies. There are, however, important exceptions to this very general rule. The application of the rule and the exceptions depends on the particular facts in each case, such as the importance of membership in the particular association, conflict, if any, with well-settled principles of public policy, and in some states, particular statutes relating to the subject. Despite these qualifications, associations, including medical societies, have great latitude with respect to membership.[17]

A. Laws Concerning Restraints of Trade Limit Enforcement of Medical Society Standards for Members

One major limitation on an association's control of membership occurs if the association's actions concerning membership have an adverse effect on a business. The association then becomes subject to the laws regulating business. Among these laws are the federal Sherman Act and state constitutional provisions and statutes prohibiting in one form or another combinations, conspiracies and contracts in restraint of trade, and monopolies and attempts to monopolize. These laws are applicable to association activities, regardless of the fact that the association is not engaged in business. If, however, the association is also engaged, directly or indirectly, in business, or combines with those who are, the association's action will be viewed even more unfavorably.

A medical society, like other associations, is subject to these laws if its activities adversely affect a business, such as a prepaid medical care plan. The fact that the society has created or cooperates with another organization providing prepaid care may color any of the actions the society takes.[18]

Four court decisions demonstrate that any medical society is on dangerous ground if it denies membership to physicians, disciplines members, or threatens to discipline members because they do or would render medical services for a prepaid plan.[19] Action of this nature may well be considered an unlawful restraint on the

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17. Illustrative of the latitude and limitations of medical societies with respect to membership are the following: Rockmore v. Fein, 99 N.Y.S. 2d 409 (S.Ct. N.Y. 1950); Harris v. Thomas, 217 S.W. 1068 (Civ. App. Texas 1920); Porter v. King County Medical Society, 186 Wash. 410, 58 P. 2d 367 (1936); Irwin v. Lorio, 169 La. 1090, 126 So. 659 (1930) reh. den.; Smith v. Kern County Medical Ass'n., 19 Cal. 2d 263, 120 P. 2d 874 (1942); People ex rel Gray v. The Medical Society of the County of Erie, XXIV Barbour 570 (N.Y. 1857) The State ex rel Waring v. The Georgia Medical Society, 38 Ga. 608 (1869); Bernstein v. Alameda-Centra Costa Medical Association, 139 Cal. App. 2d 241, 293 P. 2d 862 (1956) reh. den.

18. United States v. Oregon State Medical Society, 343 U.S. 326, 334 (1952). The Supreme Court, commenting on the medical society and its prepaid health plan, indicated that their activities in providing prepaid medical care might violate the antitrust laws. The court stated: "They are now competitors in the field and restraints, if any are to be expected, will be in their methods of promotion and operation of their own prepaid plan."

19. American Medical Association v. United States, 317 U.S. 519 (1943); United States v. Oregon State Medical Society, supra f. n. 18; Group Health Cooperative v. King County Medical Society, 39 Wash. 2d 586, 237 P. 2d 737 (1951) reh. den. (1952); Complete Service Bureau v. San Diego County Medical Society, 43 Cal. 2d 201, 272 P. 2d 497 (1954) reh. den.

business of the plan because the plan may have difficulty in obtaining physicians to carry on its business. This difficulty was aggravated, the courts observed in some of the cases mentioned above, because in those cases physicians, not members of the society, but working for the plans, were subject to disadvantages. They were not able to consult with medical society members. They could not become certified as specialists or obtain or retain staff privileges in certain hospitals. They did not have the advantage of graduate courses conducted by the medical societies and had difficulty obtaining professional liability insurance. In passing, it may be noted that this restriction on association freedom to control membership applies to all associations; it is not peculiar to medical societies.[20]

These cases show that conflict between some medical ethics and some aspects of a plan's operation does not automatically justify screening applicants or disciplining members because they work for the plan. This point is emphasized because many physicians seem to be of the opinion that the ethical conflict completely justifies such action. In the cases in which a breach of association ethics, medical association or otherwise, has been urged as a defense to a charge of violation of the antitrust laws, the courts have held that the mere use of the word "ethic" does not insulate the association from a violation of the law.

Courts will examine the nature of the particular ethic involved, its interpretation, and the reasonableness of its application under the circumstances of the particular case. Accordingly, courts have held in two of the cases referred to that a medical society was not justified in taking action against physicians working for prepaid medical care plans which employed a limited number of physicians (a closed panel), which collected money for services rendered by physicians and paid the physicians on a salary or contract basis, and which even advertised and solicited members or subscribers. The fact that patients did not have free choice of physicians and that physicians were not compensated on a fee-for-service basis was not, the courts held, justification for the actions of the societies.

In one of these cases, the Supreme Court sustained a criminal conviction of the A.M.A. and a local medical society under the Sherman Act for coercive action against a lay-sponsored prepaid plan which provided medical services through a closed panel of physicians employed on a full-time salary basis. In the words of the Supreme Court, "This plan was contrary to the code of ethics . . ." The medical profession advocated that physicians should be paid on a "fee-for-service" basis. Despite the conflict with ethics, the A.M.A. and the local medical society were found guilty.

In one state court case, the court held that the medical society had violated the state's antitrust law. The society objected to a prepaid plan because, among other reasons, the plan had a closed panel and therefore did not offer free choice of physician. The screening of applicants and threats to expel members who worked for the plan were not, in the court's opinion, justified by reliance on medical ethics dealing with free choice of physician, contract practice, and advertising and solicitation. Among the reasons given by the court for its decision were: (1) physicians in many cities working for closed-panel plans of various types on the same basis were in good standing with their local societies; (2) to require a plan to employ a larger number of physicians than required to serve beneficiaries of the plan would be unreasonable; (3) the A.M.A.'s ethics provide that "contract practice *per se* is not unethical," and the court found that the plan did not "render professional service of a quality substantially below that rendered by the average physicians . . ."; and (4) the beneficiaries of the plan had free choice of all physicians and surgeons participating in the plan and could also, if they so desired, terminate their membership and subscribe to any other prepaid plan. The society had also sponsored a plan which was in competition with the plan affected.

With respect to the ethic relating to advertising and solicitation, the courts in two of the four cases held that the plans in question did not misrepresent, oversell, or otherwise engage in improper conduct. In each case, the courts compared the promotional activities of the plans with the activities of the medical society sponsored plans and found no substantial difference.

These cases do not hold, of course, that these same ethics under other circumstances, or other ethics, may not justify action regarding membership even though the action may have an adverse effect on a prepaid plan. The Supreme Court has observed that ". . . . there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."[21]

Although there are no decisions under the antitrust laws involving the point, a court might well hold, for example, that a medical society would be justified in excluding from membership a physician who worked for a plan which persisted in false and misleading advertising and solicitation and which extolled the phy-

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20. An outstanding example in another field is Associated Press v. United States, 326 U.S. 1 (1945), reh. den. 326 U.S. 802, in which the court held invalid a bylaw which effectually denied membership in the Associated Press to a newspaper applicant which competed with an existing member.

21. United States v Oregon State Medical Society, 343 U.S. 326, 336 (1952).

sicians working for it. Interference by lay owners or administrators with the physician in the treatment of patients or poor and inadequate medical care might also be held to justify such medical society action.

In any suit filed against a medical society for excluding a physician because he works for a prepaid plan, the society will have to show that its action was reasonably adapted to maintain and advance the standards of medical practice and not calculated to restrain the business of the prepaid plan.[22] Evidence of improper advertising, lay interference with the patient-physician relationship, poor quality of medical care, and the like, must be clear and convincing with respect to the particular plan under consideration. In so far as applicable, the courts will probably compare the practices of the plan with the physician-sponsored plan in the community and with the general level of medical care to determine whether the society is actually protecting the sanctity of the patient-physician relationship, the standards of the profession, and other proper interests.

This discussion of ethics should not be construed to mean that the courts in the cases referred to held the ethics in question unlawful or improper. The courts recognized that medical societies may properly adopt standards of conduct for the guidance of the profession. Most of the difficult questions, however, arise out of methods by which adherence to these standards is sought. An ethic may be perfectly proper on its face but the manner in which a society enforces the ethic in the context of the particular situation may conflict with some federal or state law. Thus, in some of the cases referred to above and under the facts involved in those cases, the courts held that enforcement by exclusion of physicians from membership because the physicians worked for a closed-panel plan conflicted with laws prohibiting restraints of trade.

The foregoing discussion regarding the dangers of screening applicants or disciplining members who work for closed-panel plans should not, of course, cause a medical society to conclude that membership should automatically be granted to a physician simply because he works for a plan.

B. The Federal Sherman Act Applies If Interstate Commerce Is Affected

The federal Sherman Act applies only to activities which monopolize or restrain interstate trade or commerce. Two elements must be present for the Sherman Act to be applicable: First, "trade or commerce" and second, the "trade or commerce" must be interstate, and not local or intrastate, in nature.

Trade or Commerce

The statement sometimes is made that the activities of the medical profession cannot be affected by the Sherman Act because the practice of medicine is not trade or commerce. The Supreme Court of the United States, however, in the case against the A.M.A. referred to previously expressly did not pass on the question whether the practice of medicine was trade or commerce. Instead, the court ruled that the activities of a prepaid plan allegedly restrained by activities of the defendants in that case were trade or commerce. Since the activities of the prepaid plan were considered trade or commerce, the court did not have to decide whether the practice of medicine could be so classified.

As the A.M.A. case indicates, the Sherman Act applies if the activities or business restrained are trade or commerce. The fact that the individuals or organizations charged with violating the Sherman Act are not themselves engaged in trade or commerce does not exclude their activities from the Sherman Act. Hence, if activities of a medical society have an effect on a prepaid medical care plan the fact that members of the society are interested in the practice of medicine does not preclude the application of the Sherman Act.

Interstate Trade or Commerce

The Sherman Act applies only to restraints on *interstate* trade or commerce and has no application to restraints that are purely local and intrastate except in the District of Columbia where interstate commerce is not required. Interstate trade and commerce is a technical concept of such complexity that it cannot be discussed at length here. In general, the phrase is used to describe business which crosses state lines. The fact is emphasized that although restrictive activities may be entirely local in nature—that is, performed within the borders of a single state—those activities nevertheless may affect business which crosses state lines and therefore violate the Sherman Act. As the Supreme Court stated in one case: "If it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze."[23]

The fact that a state or local medical society's activities are performed within the borders of a single state is immaterial if these activities affect the business of a prepaid plan which crosses state lines. It would likewise be immaterial that the medical society is not engaged in interstate commerce. In some instances, however, the plan's operations will be entirely confined to one state and therefore the society's activities may

22. *See instruction to the jury upheld in American Medical Association v. United States, 317 U.S. 519 (1943), at page 533.*

23. *United States v. Women's Sportswear Manufacturers Association, 336 U.S. 460, 464 (1949).*

not come within the Sherman Act.[24] In order, therefore, to determine whether the Sherman Act applies, a careful analysis of all of the facts pertaining to the operation of the particular prepaid plan will be required. This becomes doubly important in view of the expansion of existing plans and the development of new plans which may operate directly or indirectly in more than one state.

Among the factors which may be considered pertinent in determining whether interstate commerce is involved, although any one or any combination of them may not be conclusive in any particular case, are the following: To what extent does the prepaid plan operate in more than one state? To what extent does the plan have subscribers or members in more than one state? To what extent does the plan, directly or indirectly, through arrangements with other plans, cover services in other states, or in its home state for individuals residing in other states? To what extent does the plan negotiate with employers or labor unions concerning the medical benefits for employees or union members residing in more than one state? To what extent do the employers and unions make payments to the plan from offices in other states? To what extent does the plan make benefit payments from its home state to persons, hospitals, or organizations in other states? To what extent, if any, is there an exchange of personnel and supplies between the plan facilities in one state and facilities of plans in other states? To what extent are materials and supplies for plan facilities and for physicians serving the plan purchased from out of state? To what extent does the plan advertise in more than one state, either directly or through a cooperative effort with other plans?

Although a medical society's activities and the business of a prepaid plan might in themselves be entirely local in nature, under some circumstances the Sherman Act might be involved if these local situations can be tied into activities of other societies and plans in other states. In that event local situations might lose their significance as local and intrastate matters and might be viewed as part of a multi-state program.

C. State Antitrust Laws May Be Applicable

In addition to the Sherman Act, however, consideration should be given to the applicability of state antitrust laws which apply to trade and commerce within the boundaries of each state and to other state laws relating to interference with business. Each state has such laws, many of which parallel the federal Sherman Act. In one of the cases referred to earlier in this section, a county medical society was held to have violated a state's laws relating to restraints of trade by screening applicants for membership and threatening to expel members who work for a closed-panel plan.[25] One difficulty is that the scope of the antitrust laws of many of the states has not been construed in modern decisions. Clearly, however, a medical society before denying membership to applicants or disciplining members because they work for a closed-panel plan, and before engaging in activities which may adversely affect the business of a plan, should consult a lawyer skilled in the field who is, in addition, familiar with local law.

D. Other Society Actions May Be Illegal

Independent of exclusion from membership but equally as dangerous, of course, are any other coercive activities by a medical society designed to restrain the business of a medical care plan. In two of the cases referred to previously, the following actions were found to be coercive and unlawful under the circumstances: inducing hospitals not to afford staff privileges to plan physicians, denying plan physicians consultation with society members, preventing physicians from working for a plan and similar activities.

E. Other Areas of Lawful Society Activity Concerning Prepaid Plans

The question properly arises whether a medical society may engage in any conduct to change the policies of a prepaid plan which in the opinion of the society are not in the best interests of the profession or of public health. There are certain well-recognized areas of lawful activity available.

A medical society may lawfully and properly use education, persuasion, and cooperation in an effort to eliminate the evils or potential dangers which the society believes to exist, provided the society's statements are fair and accurate and are not part of a conspiracy to restrain trade. Activities of this nature have been utilized both at national and local levels for many years.

In the period following World War II, the A.M.A. has, for example, sponsored conferences concerning various types of plans in the miscellaneous and unclassified category. Conferences have been held with cooperative plans, medical directors of union health centers, and the medical personnel of the United Mine Workers of America Welfare and Retirement Fund. There have, of course, been strong differences of opinion and vehement criticisms of some facets of various plans. The A.M.A. House of Delegates has adopted guides for physician-sponsored plans, lay-sponsored plans, and

24. *United States v. Oregon State Medical Society*, 343 U.S. 326 (1952). Although the operations of a prepaid plan adversely affected by a society's activities are entirely local, the society may nevertheless be subject to the Sherman Act if it operates a plan or combines with a plan that operates in interstate commerce.

25. *Group Health Cooperative v. King County Medical Society*, 39 Wash. 2d 586, 237 P. 2d 737 (1951) reh. den. (1952).

union and management health centers. In June, 1957, the House of Delegates also adopted the "Suggested Guides to Relationships between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund." These guides were developed by A.M.A. councils and committees after consultation with interested parties.

The A.M.A. has encouraged state and county medical societies to develop committees to study prepaid plans in their communities in order to aid in resolving problems to the mutual satisfaction of all concerned and to offer advice and counsel to them. In addition, councils and committees of the A.M.A., acting in an advisory capacity only at the request of interested parties, have aided in resolving disputes between prepaid plans and state and county medical societies.

Argument, persuasion, and publicity have also been used by state medical associations and county medical societies. By these means in some areas disputes concerning features of a particular plan have been resolved from time to time. In other instances, there has been cooperation between the medical profession locally and the plan in an effort to resolve problems amicably. Societies have established committees for this purpose. Some societies and committees have assisted particular plans in their organizational period and have aided them in various ways in accomplishing their purposes. In other instances, societies have passed resolutions highly critical of particular plans or their methods of operation and have given wide circulation to these opinions, although no coercive action was taken by the societies. This publicity has been designed to gain public support for the viewpoint of the medical society.

Competition is also available to the medical society if it has objections to the manner in which a particular plan in its community is operated. One case in this field, which the society won, turned on the fact that several years prior to the suit the society had abandoned its policy of coercive activities against a particular plan (including exclusion of member physicians who worked for the plan) and instead developed its own plan, which was eminently successful. Other medical societies have encouraged the development of plans and expansion of coverage to meet the particular local competitive situation.

A medical society may also properly present its views to the legislature for the purpose of obtaining legislation to protect the public and the profession, provided the society's action is not part of a conspiracy to restrain trade. The society may set forth its views concerning legislation to authorize creation of particular plans either by suggesting safeguards or by opposing the legislation. It may, of course, propose its own legislation.

Finally, prepaid health plans sponsored by medical societies, and perhaps physicians unaffiliated with any plan, are equally entitled to the protection of the antitrust laws. The method of promotion and operation of any prepaid plan, not merely the physician-sponsored plans, may lead to restraints and monopolies in violation of these laws.

Courts will certainly scrutinize very closely any methods or arrangements which may result in any plan acquiring a monopoly or near-monopoly in this field in any locality. In two of the cases referred to previously, the courts, from their comments in the opinions, were obviously concerned that a holding in favor of the medical societies or their plans might result in their plans having a monopoly in the prepaid medical care field. So also, practices and arrangements by other plans may be objectionable if they have the effect of excluding from the field other types of plans, including medical society plans, or the practitioner unaffiliated with any plan.

There is a fear on the part of a large segment of the medical profession that certain types of prepaid plans have the potentiality of regimenting physicians. This potentiality, many believe, lies in the increasingly large sums available for prepaid health services under the control of organizations having closed panels of physicians and, for all practical purposes, "captive patients." The comments of the Court of Appeals of the District of Columbia in the A.M.A. case are particularly pertinent in this connection: "... members of the medical associations ... perhaps may find in Section 3 [the section of the Sherman Act applying to the District], as we construe it, their only protection in the right to practice on a fee for service basis."[26] The same observation follows more strongly with respect to the right of a medical society to conduct its own prepaid health plan free from unreasonable restraints.

Whether in any given locality any prepaid plan in its methods of operation is, or will be, unlawfully restraining trade can only be determined by a careful analysis of the operations of that plan. If interstate commerce is not affected, the scope of the applicable state laws will have to be considered.

SUMMARY

A medical society may adopt standards for its members, but enforcement of these standards by screening applicants, or disciplining members, or by other action against them, because they work for a closed-panel plan, in some circumstances may violate federal or state laws relating to restraints of trade or interference with business. The fact that some facet of a plan's operations conflicts with the ethics of a society is not automatic justification for action by that society. Whether the

26. *United States v. American Medical Association, 110 F. 2d, 703, 712 (C.A.D.C. 1940), cer. den. 310 U.S. 644.*

society's action is justified will depend on appraisal of all pertinent facts with a view to determining whether the action is aimed at protecting the quality of medical care, the patient-physician relationship, the standards of the profession, and the like, or is instead calculated to restrain a legitimate business.

A medical society may, if it objects to a plan or some features of its program, express these objections by argument, persuasion, and cooperation, by legislative activity, and by competition. Medical societies and plans which they sponsor are also protected by the laws concerning restraints of trade from undue restraints which may be imposed by other prepaid plans.

III. THE INTERNAL STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION

As the cases referred to in the previous part of this section disclose, most of the legal problems which arise in this field are considered and dealt with at state or county levels. This is to be expected, since most of the laws relating to the organization, internal structure, and operation of prepaid plans are state laws which vary from state to state and since medical society activities in relation to the plans vary in different localities. Another factor which contributes to this result is the federative nature of the A.M.A.'s structure. A very brief description of this structure is sufficient because it is well known to physicians although apparently misunderstood or ignored by many outside the profession.

The A.M.A. is a federation of state (including territorial) medical associations, which are known as constituent associations. There is only one constituent association in each state or territory. The constituent associations may charter county or district medical societies. A number of these local societies have been chartered. They are not chartered by the A.M.A. but by their respective constituent associations. Each state medical association may select a certain number of delegates to the A.M.A. House of Delegates.

The A.M.A. has its own constitution and bylaws and code of ethics. The state associations and county or district societies generally have their own constitution and bylaws, and, though they subscribe to the A.M.A. code of ethics, they may also adopt stricter requirements. Some societies have done so.

Because the A.M.A. is a federation, the state, county, and district societies have considerable autonomy. They are not under any obligation to clear their activities with the A.M.A. Resolutions adopted by these organizations are actions of those organizations only, unless subsequently adopted by the A.M.A. House of Delegates. Many activities of these organizations are known to the A.M.A. only after they have occurred, if at all.

Not all doctors of medicine are members of the A.M.A. There are a considerable number of physicians who are members of a local society and a state association but who have not applied for membership in the A.M.A. In most states, a physician does not automatically become a member of the A.M.A. when he joins his local county society and state association, although some state associations require a physician to become a member of the A.M.A. when he joins the state association. In order for a physician to become a member of the A.M.A., however, he must first be a member of a local society and of a state association.

The qualifications of applicants for membership in the local societies or state associations are determined entirely by those organizations. If the applicant is accepted by the proper local society and is certified to the A.M.A. as a member of the state association, he is automatically eligible for A.M.A. membership. The A.M.A. has only limited authority to accept or reject his application. Similarly, disciplining of members originates in the local society. The A.M.A. has only limited authority in this respect. A disciplined member of a local society may appeal the decision to the state association and, if unsuccessful there, to the A.M.A. Judicial Council, which is the ultimate authority on interpretation of the A.M.A. constitution and bylaws and the Principles of Medical Ethics. A disciplined member cannot appeal to the A.M.A., however, if he is a member only of the county society and the state association but not a member of the A.M.A. As stated previously, a considerable number of physicians have not applied for A.M.A. membership although they are members of local societies and state associations.

III. FREE CHOICE OF PHYSICIAN

The medical profession exists to serve the physical and mental needs of all humanity. The tools of the physicians are life-long study, intelligent use of scientific equipment, and dedicated service.

The medical profession also has long had the objective of rendering good medical care at a cost the people can afford to pay.

There are many factors in the attainment of this goal. One of these is the freedom of choice of physician which has been, and still is, a fundamental principle of medical practice.

The twentieth century has seen basic freedoms of mankind restricted or even abolished in many lands. The physicians of the United States believe that it is their duty to preserve fundamental freedoms to prevent the deterioration of medical care which has resulted in many areas because of restrictions on the forms of medical practice.†

"Freedom of choice" means the right of the individual to exercise, without restraint, selection among alternatives. Furthermore, as applied to medical care, an individual should have the right to select a physician of his choice. The medical profession subscribes to, supports, and strives to attain complete acceptance and application of this principle of "freedom of choice."

The medical profession is aware, however, that the principle has been restricted in its application in some situations. Among such instances are the following: by action of law; by social and economic changes leading to new methods of financing the cost of medical care; by action of the profession in establishing systems of staff appointments granting limited privileges; by the rating of physicians for the performance of various types of medical care; by the certification of specialists; by action of hospitals as recognized in the 1947 Report of the Judicial Council which, in part, stated that,

> In order that a high standard of service be maintained, hospitals may limit somewhat the number of physicians who deliver medical services in their institutions and even assign a physician to certain definite fields in accordance with his training and experience.

Another example is the reaffirmation by the House of Delegates in December, 1957 of the 1927 Report of the Judicial Council which stated that a contract would be considered unfair and unethical,

> . . . when a *reasonable degree* of free choice of physician is denied those cared for in a community where other competent physicians are readily available. . . . (Emphasis added).

In December, 1955 the House of Delegates adopted the following in its statement on "Medical Relations in Workmen's Compensation."

> Disabled employees should have the right to accept physicians' services provided by employers, or to select another attending physician from a register of all other physicians in the community willing and *qualified* to perform the essential service. (Emphasis added).

Other examples of apparent conflict between principle and its application are the following: Chapter I, Section 2, page 5 of the Principles of Medical Ethics of the A.M.A. (December, 1955) which is contained in the "Guides for Evaluation of Management and Union Health Centers" states, in part, that, "Physicians . . . must dispense the benefits of their special attainments in medicine to all who need them." Elsewhere,

†Dr. Price comments: To balance the statement, I should like to point out that the twentieth century has also been marked by new freedoms, new opportunities for social and scientific experimentation, improved social status, and better living standards. This is particularly true with regard to medical care made available through vast funds resulting from collective bargaining which seeks to secure more medical care for large industrial groups.

however, in the Principles of Medical Ethics (Section 5) it is stated that, "... a physician may choose whom he will serve"—in which case the patient may be denied his choice. In upholding the concept of "free choice of physician" it has been stated that,

> Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers. (*Suggested Guides to Relationships between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund*, adopted by the House of Delegates, December 1957).

The latter statement has led to controversy since physicians in a community may be reluctant to state frankly their opinion as to another's qualifications and yet the judgment of concerned physicians elsewhere might not be acceptable.

These historical developments have acknowledged that choice of physician is for some people not free in the literal sense of the word. Nevertheless, numerous resolutions adopted by the House of Delegates have continued to reiterate the conviction that "free choice of physician" by the patient is essential to the provision of medical care of good quality. Some have been confused because they have failed to distinguish between acceptance of the principle and restrictions on its application. The foregoing statements of policy are the result of earnest efforts to resolve conflicts between the idealism which is an important element in making the practice of medicine a profession and the practicalities of this modern social and economic era. As citizens, physicians have the obligation to resist trends which they believe are detrimental to the best interests of society. As physicians, our additional function is to provide care of good quality to people at a cost they can afford. Since free choice of physician has been denied in some mechanisms for the provision of medical care, it is incumbent upon the profession to understand the reasons for this action and to be aware of its effects upon the quality of medical care.

In the closed-panel, direct service, type of plan visited, the committee has uniformly observed care of good quality being made available to patients who do not have "free choice of physician" in the literal sense of the term. This is possible when sponsors of these plans have accepted their obligation to see that plan physicians are well qualified. Financial arrangements exist which make possible the prediction and budgeting for the cost of providing service. Based on its observations, the committee finds that the absence of "free choice of physician" does not necessarily result in inferior care; but the committee in no way intends to state that good quality medical care was rendered in these plans because of the absence of free choice.††

The committee has noted a trend toward offering the individual employee more than one plan for medical care so that he may exercise his choice. The committee believes that this development is commendable. It indicates that proponents of some closed panel plans have come to recognize the desirability of a wider choice of physician by the patient.

"Free choice of physician" is an important factor in the provision of good medical care. In order that the principle of "free choice of physician" be maintained and be fully implemented the medical profession must discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.

Attention is called to Section 4 of the Principles of Medical Ethics, adopted June, 1957 which states,

> The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.†††

In summary, the medical profession is determined to maintain the highest possible standards of medical care. Freedom of choice is an important factor in the achievement of this goal.

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††Dr. Price comments: The last part of this sentence is gratuitous. In my opinion, this is not the issue. It tends to divert attention from the fundamental issue, which is the provision of good quality medical care despite the presence of social or economic barriers. Good quality medical care can be provided by physicians, regardless of the framework within which medicine is practiced. The physician who has a deep interest in humanity often makes great personal sacrifices to live up to the Hippocratic Oath to provide care to the sick and needy. Such dedication is most likely to be nurtured in an atmosphere where freedom to practice medicine without interference is guaranteed—regardless of whether "open" or "closed" panels are involved.

†††Dr. Reuling comments: "Free choice" must always stand as a principle, and we should never give up fighting for principles. However, it is going to become only a hollow phrase unless the county societies throughout this country vigorously, and without fear or favor, clean their own house in accordance with Section 4 of the Principles of Medical Ethics.

IV. THIRD PARTY RELATIONSHIPS IN MISCELLANEOUS AND UNCLASSIFIED PLANS

This section is concerned with the relationships which should exist among plan members, and physicians, and the many types of medical care plans, particularly closed panel plans, which the committee has studied.

As Part II of the Commission's report discloses, the medical profession has dealt for many years with various organizations which assist individuals in paying for medical care or which arrange for the provision of medical care. Due to many social, economic, and legal factors the number of, and enrollment in, these organizations has increased. They are often referred to as third parties, and are here defined as mechanisms which, for any reason, enter into the relationship between the patient and his physician. Such an all-inclusive definition is necessary because third parties assume such a wide variety of forms and activities.

Among the third parties are the Miscellaneous and Unclassified plans studied by the committee. Any consideration of the relationships that should exist among these plans, and patients, and physicians, must be predicated on recognition of the following:

1. Some of these mechanisms have been associated with medical practice for many years.
2. Many of them are likely to remain in the field of medical care and become increasingly important to patients and physicians.
3. In many states closed panel plans can be legally organized and operated as a result of legislation and court decisions.
4. The development and operation of these plans have been encouraged, in part, as the outcome of collective bargaining between unions and employers.
5. Many of these programs are claimed to be an economic necessity for many persons whom they serve.
6. The stated objectives of these plans are the arrangement for payment and/or the provision of a greater amount of good medical care at a cost that can be afforded.

Problems have arisen between these plans and the medical profession. Some of them have been resolved but others have persisted and new problems continue to arise.

Many third party mechanisms in the group of Miscellaneous and Unclassified plans have interfered with free choice of physician by establishing closed panels of physicians. Some of them have caused adverse physician reaction by adopting a method of compensation other than the usual fee for service. Some of the plans have established their own professional standards which limit the activities of plan physicians and exclude some physicians from participating in the plan. A great many physicians believe that the development of closed panel plans is a threat to private practice. Some physicians object to these plans because they change the traditional form of medical practice. Some physicians contend that many of these plans, through administrators, or governing boards, or both, interfere with the patient-physician relationship; some, that plan members cannot secure good quality medical care, and some, that closed panel practice has the potential to affect adversely the quality of medical care. It is contended that the personal freedom in the practice of medicine might be adversely affected if all physicians should ultimately be obliged to associate themselves with these plans in order to practice medicine. It is contended by many physicians that some of these plans utilize promotional methods and exercise such absolute economic controls as to create a monopolistic effect.†

These contentions have been subjects of controversy between segments of the medical profession and various plans. Notwithstanding these disputes, other physicians appear to be satisfied with their relationships

†Dr. Price comments: Monopoly in any form can only be objectionable if it possesses characteristics which are inimical to the best interests of society. This is true regardless of whether management, labor, a professional society, or any other organized body promotes it. The reference to "monopolistic effect" might therefore be equally applicable to Blue Shield Plans in those states which have passed special enabling legislation to give this organization the sole legal authority to offer prepaid medical care to the public.

with a closed panel type of practice as well as with other types of third party mechanisms.

In order to resolve existing disputes and to avoid conflict, there are certain basic concepts which should guide the relationships among plan members, and physicians, and these plans. The recognition of these concepts would provide a basis for mutual understanding and cooperation and aid in the achievement of a mutual objective of both the medical profession and these third parties—the provision of good medical care at a cost which can be afforded. The most important of these concepts, relating to plan members, physicians, and these plans, are set forth below.

PLAN MEMBERS

Medical care of good quality should be available to plan members at a cost which will not be a deterrent to the procurement of such care. They should be routinely informed of the amounts of the contributions of the employer and employee which are expended for such services. Mechanisms should be established to hear and resolve complaints of patients concerning the plan of which they are members. Patients should have the widest possible choice of physicians from among those serving in a closed panel or from among other physicians in the community who are willing and competent to render the service. In the latter instance, it is essential that there be 1) a mutually acceptable determination of fees which a closed panel can pay and the willingness of physicians to provide services for those fees, and 2) the assurance of competency as set forth in subsequent paragraphs and in Section III on "Free Choice of Physician."

Plan members should become familiar with the scope of services afforded by a plan to the end that they will be used reasonably and effectively.

PHYSICIANS

Physicians are entitled to practice medicine without lay interference in decisions on predominantly professional matters. Those affiliated with plans should have working conditions and remuneration which will assure the provision of good medical care. They may accept remuneration from any plan on any basis which is not in violation of the Principles of Medical Ethics. The medical profession may reasonably expect that plans should and will cooperate with it in seeking consultation and guidance in the attainment of good medical care.

Physicians who provide services under the plan should render competent medical care to members of plans at a cost which will not be a deterrent to the procurement of good medical care. They should use reasonable efforts to prevent unnecessary utilization of plan services and facilities. The medical profession has a dual responsibility of assuring the competence of its members and of disciplining them when evidence of incompetence or abuse of plan benefits are present. Physicians have the obligation of offering guidance and consultation to third parties to improve the quality of medical care, and of maintaining active liaison mechanisms to resolve problems and controversies which may arise.

THE THIRD PARTY IN MISCELLANEOUS AND UNCLASSIFIED PLANS

Under proper legal authority, these third parties are privileged to develop medical care plans. They may reasonably expect that competent medical care will be rendered by all physicians who provide services under the plan to their plan members at a cost that will not be a deterrent to the procurement of such care. They may justly expect that their plan will not be subject to unnecessary utilization by their plan members. Their obligation to expend funds efficiently should be recognized. They are entitled to the cooperation of the medical profession in developing and maintaining relationships which are ethical.

These third parties should hold administrative expenses to an acceptable minimum so that the highest possible percentage of their income is spent for medical care. They should make clearly known to beneficiaries the nature and extent of services or benefits which are available. The cost to members for plan participation should be made known to them by the plan. They should provide the beneficiary with the widest possible choice of physicians as stated in the paragraph entitled "Plan Members." They should refrain from interfering in patient-physician relationships and should prevent lay interference in the practice of medicine. When plans contemplate entering a community, they should give consideration to the effect a closed panel plan might have on the practice of physicians who are located there and on the effect of medical care available for the community, particularly that segment which is not affiliated with the plan. Every effort should be made by the third party to minimize any adverse effects. These third parties should seek the counsel and guidance of the medical profession in the initiation, development, and operation of plans. The cooperation of the profession should be enlisted in resolving problems and controversies which may arise.

The foregoing represent the bases upon which conclusions and recommendations have been formulated with respect to the third party in the group of Miscellaneous and Unclassified plans and its relationships with plan members and physicians. These appear in the following sections of this report.

V. CONCLUSIONS

The committee has arrived at conclusions concerning various characteristics of the miscellaneous and unclassified plans, including 1) the nature and methods of operation of the various types of plans through which persons receive the services of physicians, 2) the effect of these plans on the quality and quantity of medical care provided, and 3) the legal and ethical status of the arrangements used by the various plans. These conclusions deal with plans in the United States in general, and with plans visited in particular. The conclusions are divided into four parts:

A. Conclusions relating to plans in general
B. Conclusions relating to plans visited
C. Conclusions relating to laws applicable to these plans, particularly closed-panel plans, and to the relationships between the medical profession and these plans
D. Conclusions concerning the objectives of the Commission

A. CONCLUSIONS RELATING TO PLANS IN GENERAL

1. The prototype of many of the miscellaneous and unclassified plans in existence dates back to the past 50 and 100 years.
2. These plans have not grown in number and enrollment as fast as many physicians believe. They are widespread geographically, but enrollment is concentrated in a few plans.
3. Their origin and development have been influenced by economic, social, political, and ideological factors as well as technological developments in industry and medicine.
4. There has been a tendency in recent years to extend them to other segments of the population than those segments they were first designed to serve. Recent developments indicate that they may assume greater importance and faster growth.
5. Industrialized areas have been the locus of the greatest growth of these plans, but the ideological concepts which have influenced the growth of these plans in those areas have also encouraged their development in other areas. Where unions have favored the expansion of such plans the money for financing them has been obtained, in large part, through collective bargaining for health benefits. Collective bargaining, both local and nationwide, for health benefits may result in further expansion of these plans.
6. The number of union and consumer sponsored plans and their enrollment have increased during the past fifteen years. This growth is likely to continue. (See Part II, Fig. 4, page 13).
7. The scope of these programs has been changing. At first, plans in this group were established to provide for the medical needs of beneficiaries due to the unavailability or inadequacy of existing medical personnel or facilities in remote areas. Later, this concept of medical care was extended to other areas where mechanisms for the provision of medical care were available for occupational and non-occupational illness and injury.
8. The trend of these plans is to provide services by physicians in closed panels.
9. A characteristic of the prepaid, direct service, plans is the establishment of facilities with closed panel staffs. In some instances, plans own and operate their own hospitals.
10. The scope of medical services provided through these plans ranges from diagnostic to comprehensive medical care.

11. The benefits provided through various miscellaneous and unclassified plans are broader and more comprehensive than those provided through most other prepayment mechanisms.
12. In industry the ultimate cost of medical care as provided through these plans as well as through other prepayment mechanisms is financed largely through collective bargaining. This is finally borne by the general public in that the cost of the plan is reflected in the price of the product or service involved.
13. Closed panel, direct service, plans have not replaced other forms of medical care plans, but have stimulated some of the other plans to increase their coverage.
14. By and large, the medical profession became concerned with these mechanisms for the provision of medical care when issues arose which affected the practice of medicine; such as, the economic threat posed to the physicians in the community, the type of care provided, the long-range influence on the quality of medical care, the threat of lay domination, and the employment of large numbers of physicians on salary or retainer.
15. Lay administrators, solely, direct the activities of a small percentage of plans. Administrators who do not realize the limitations of their medical knowledge may interfere with the proper performance of a plan and lower the quality and quantity of medical care rendered.
16. The quality of medical care provided by these plans would be adversely affected if, for example, physicians serving them: 1) carried too great a work load, 2) were required to exceed their professional limitations, 3) were restricted in their medical practice by lay administrators or non-medical administrative boards.
17. It is increasingly evident that a trend is developing among some sponsors of plans and among some plans to require as a condition for enrollment that each member of a group be given a choice of more than one plan in the community.
18. Physicians have affiliated themselves with these plans for the following reasons: to supplement income; to participate in group practice; to gain experience and practice more rapidly; to develop a private practice by referrals; to serve certain groups of patients and satisfy personal ideals; to obtain job security and various personal benefits including regular hours of work, paid vacations, pensions, etc.
19. Medical societies have taken various attitudes towards these plans. Some have cooperated; others have expressed disagreement with the methods used to attain the stated objectives of the plans. Some have made no effort to inquire into their methods of operation, have criticized the ethical arrangements involved, have taken no position on them, or have actively opposed them for various reasons.
20. Not all members of the medical profession are equally informed of the various economic problems involved in the provision of medical care to certain groups of people or in certain areas of the country.
21. The attitudes of many medical societies towards these plans are based upon the reported observations of their members with regard to the quality of medical care provided to plan participants, the reactions of their patients to care provided, their judgment of professional and ethical relationships involved, the threat to physicians' income, and the changes in forms of medical practice.
22. Some plans embark upon programs without prior consultation with local medical societies. Such actions create gaps in understanding and may result in conflict.
23. The various factors which are causes for conflict must be recognized both by these plans and the medical profession.
24. Problems and controversies affecting these plans and the medical profession can be resolved on a foundation of recognition of the valid interests and obligations of plan members, physicians, and third parties, as set forth in Section IV in the report of the Committee on Miscellaneous and Unclassified Plans.
25. "Free choice of physician" is an important factor in the provision of good medical care. In order that the principle of "free choice of physician" be maintained and be fully implemented the medical profession must discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.
26. An appropriate committee at A.M.A. level is needed for investigation of, guidance for long-term solutions of, and assistance in the resolution of controversies between the medical profession and these third parties. Such a committee would be dependent upon the collaboration of similar units at the state and county medical society levels.

B. CONCLUSIONS RELATING TO PLANS VISITED

The committee has arrived at certain conclusions as a result of its visits to various plans. The committee has described in various parts of this report the nature of the study it made in visiting these plans and the general scope and limitations of its inquiries. The conclusions set forth below are based on, and are necessarily qualified by, the extent of the committee's investigation.

1. Beneficiaries of many of the plans visited comprise for the most part the lower income groups in the un-

skilled, semi-skilled, and clerical occupations. Some plans with large enrollments accept subscribers representing a cross-section of community occupations at any income level.

2. Most plans which designate themselves as "prepaid comprehensive" plans make additional charges for injections, medications, laboratory and x-ray services, and home and office calls. Patients in some plans utilize private physicians for a variety of reasons, some of which are: because home care is not readily available; because it may be more convenient to do so; because they may wish to preserve the traditional patient-physician relationship if the cost is not burdensome. Because there is no unanimity of opinion as to what is included in "prepaid comprehensive medical care," the use of this term by a medical care plan is misleading.
3. Persons who have not experienced conventional medical care, or who have not been educated to seek medical care when needed, or whose socio-economic status is low are more likely to find these plans satisfactory than are those for whom the converse holds.
4. The claims of these programs as to their value in "preventive medicine," which their proponents contend is inadequately provided by physicians in the community, have been exaggerated by many of these plans. In the main, the plans are utilized by members for diagnosis and treatment when symptoms of illness become evident.
5. Regardless of the program these plans undertake, there is evidence that they further health education and emphasize the importance of seeking medical attention when symptoms of illness appear.
6. Medical care for many persons in the low income groups now covered by these plans has improved. Some of these people live under conditions which make it difficult for them to obtain adequate care through the usual available sources.
7. The committee believes that good medical care is being provided, within the scope of services offered, by the units (of the plans) visited.
8. Although patients are assigned on the initial visit, in most plans, to specific physicians for examinations, work-up, and treatment, they may select any plan physician during subsequent visits. Such choice is limited by the hours served by the physician and the time available to the member to visit the plan.
9. An effort is often made to have the patient select a personal physician among those serving the plan.
10. The continuity of care provided varies from plan to plan. It depends upon the scope of services provided, the effectiveness of administration, professional relationships established, the manpower and facilities available, and the degree to which patients are motivated to maintain contact with the plan.
11. Uniform definitions and criteria to measure utilization in these plans are needed.
12. Many plans are financed by the earnings of participants as a result of collective bargaining. This contribution to the plan which the individual may or may not favor is usually compulsory as a condition of employment. His source of medical care is determined by the plan to the extent that he is subject to additional expense if he secures it elsewhere. A recent tendency to offer choice of plans has been noted.
13. There is a small but significant number of patient complaints in different plans. The outstanding reasons deal with undue waiting periods for examinations, the physician's attitude toward the patient, and the amount of time allotted during the patient's visit to the plan.
14. With some exceptions, there are few or no systems of documenting patient complaints about the plan, their causes, and steps taken to correct them, but the committee gained the impression that the plans were sensitive to complaints and made reasonable attempts to deal with them.
15. The technical equipment and physical facilities used by the plans appear to be satisfactory for the types of services rendered.
16. Some plans utilize the services of local physicians who are in private practice and who desire to devote specific hours of work to the plan's program. Other plans have brought physicians into the community. The latter method has sometimes aroused the concern of the medical profession. Justification for this method was claimed on the ground that physicians in the community were either unavailable, or unqualified, to render the type of medical services desired by the plans.
17. With some exceptions, physicians serving these plans find their remuneration and fringe benefits to be acceptable. In some plans, the compensation appears to be lower than the income of physicians in private practice in the community.
18. The professional training of physicians who provide services in the plans visited appears to compare favorably with that of other physicians in the community.
19. On the whole, physicians serving these plans appear to have sufficient time to care for patients.
20. The majority of the plans do not have medical representation on their policy-making bodies. However, their governing boards seek the advice of physicians in various ways before making decisions which involve medical policy.
21. Medical advisory councils, consisting of prominent physicians in the community not associated with the

plans, are not utilized as frequently as they should be as a source of advice in medical matters and as a deterrent to lay domination.

22. Although little evidence of lay domination was found in the plans visited, it is apparent that the threat of lay interference is ever-present and may exert itself in various ways and degrees. This could result in interference with the independent thinking and actions of physicians, result in decisions which reflect uninformed concepts held by lay boards, and thus affect adversely the quality and quantity of medical care.
23. The person who has the authority for hiring and firing personnel is in a position to influence the quality and quantity of medical care provided by the plan. The observed pattern whereby some lay administrators are given equal status to that accorded to medical directors contains elements which may adversely influence medical care.
24. Medical societies have displayed different attitudes toward various closed panel, direct service, plans, depending upon the latter's source of sponsorship, despite the fact that the plans may contain similar characteristics. Plans sponsored by management are, at present, less often regarded with disfavor than those sponsored by union or consumer groups. The plans sponsored by unions and consumers are of more recent development, tend to cover larger numbers of people, and evidence the increasing power of these groups in our society.
25. Controversial attitudes on the part of medical societies usually result from objections to the structure and activities of the plan rather than the professional abilities of the plan physicians per se.
26. Physicians serving most of these plans are members of local and state medical societies. In a few areas some of the physicians serving certain plans with large enrollment have been accepted for membership in the local society but other physicians working for the same plan have not yet been accepted for membership. In these and other areas, plan physicians have held and do hold elective positions or committee appointments in medical societies.
27. The extension of closed panel, direct service, plans to the entire population could serve as a deterrent to qualified individuals to enter the practice of medicine because of inherent characteristics of these plans which, of necessity, limit the physician's freedom insofar as his mode of practice is concerned. Many qualified individuals might be discouraged from entering the practice of medicine if conditions exist which would significantly limit their individual freedom. This individual freedom has played a major role in providing a high standard of medical care. The committee believes that, ultimately, such a development could have an adverse effect on the quality of medical care.
28. There are segments of the population for which choice of physician is actually limited or non-existent due to geographic, social, economic, or other factors.
29. There are several elements which may contribute to the relatively low cost to the individual plan member for the type of service which the direct service, closed panel, plan offers. Among these are the following:
    a. Not all members eligible to receive services utilize the services of the plan.
    b. Plans can predict costs of professional services since most of their physicians are paid a salary, retainer, or other fixed amount of money, and ultimate limits of compensation are established.
    c. The plan can eliminate duplication of equipment, personnel, ancillary diagnostic facilities and administrative costs incident to non-group practice, thus effecting economies.
    d. Savings can be effected by bulk purchases of equipment, supplies and drugs.
    e. In at least one plan, a certain proportion of the income derived from the care of private patients by physicians employed full-time by the plan is used to pay part of the physicians' fixed salaries.
30. The committee observed that, in at least one area, a local medical society had developed a prepaid plan with broad coverage to subscribers with lower incomes in order to compete with a specific closed-panel plan. Greater choice of physician is provided since any member of the medical society may elect to participate in this plan.
31. The responsibility of a closed-panel plan physician is divided between his patient and the plan by which he is employed.
32. The medical profession has accepted group practice as a means of providing medical care and prepayment as a means of financing medical care. However, when group practice and prepayment are combined in a plan in such a way that their benefits can be obtained only from a particular group of physicians, many physicians look with disfavor upon such a plan.

C. CONCLUSIONS RELATING TO SOME APPLICABLE LAWS

The committee has had prepared a "Statement Concerning Laws Relating to Miscellaneous Type Plans." Set forth below in summary form are some of the conclusions in that "Statement." The committee recommends that the "Statement" should be read in its entirety so that the conclusions can be read in context and the applicable laws and legal principles clearly understood.

1. As applied to the miscellaneous plans, the term "corporate practice of medicine" has been used in many different ways to describe not only prepaid plans but other arrangements by which medical service is made available to various groups by different corporations, such as corporations organized for profit or not for profit for that purpose, industrial organizations, fraternal groups, hospitals, cooperatives and health centers. The phrase has been used to describe arrangements in which the organization providing or agreeing to provide the service is not a corporation but, for example, a partnership, trust or association. The phrase "corporate practice of medicine" is a misnomer when used to describe a plan in which a corporation is not involved. Insofar as the phrase is used by some to imply that a particular arrangement or plan is universally illegal, it can be misleading.
2. The law applicable to the organization of miscellaneous plans varies from state to state. As a result of court decisions in some states, legislation and changes in social philosophy which have occurred in this country, miscellaneous prepaid plans, particularly closed-panel plans, can now be legally organized and operated in some states even though a corporation is involved and the plan engages in advertising. There is no constitutional provision or inexorable principle which prevents a state from authorizing a corporation, including a closed panel, to provide medical care. The question is one of state policy determined by the legislature or by the courts in construing state laws.
3. State laws do not universally prohibit a corporation from utilizing a closed panel in the operation of a prepaid plan. Unquestionably, in the absence of permissive legislation this practice in some forms is barred in some states. It is clearly lawful in other states when conducted by not for profit corporations organized under general corporation statutes or enabling legislation. Between the two extremes, in other states, these closed-panel plans are lawful in varying degrees and forms. Similar variations are found with respect to internal structure and operation. Partnerships, trusts, unincorporated associations and other devices, rather than corporations, have been used in organizing these plans, in some instances to avoid challenge under court decisions.
4. The Taft-Hartley Act has influenced the legal form of some plans in that it permits payments to be made by employers through collective bargaining to trusts established by employee representatives for the purpose of providing, or buying insurance for, medical care for the benefit of employees and dependents. The law neither prohibits nor requires medical representation on the governing board of the trust.
5. Although medical societies, like other associations, have considerable latitude with respect to membership, their control of membership is subject to important limitations. A major limitation occurs if the society's action concerning membership has an adverse effect on a business. Court decisions demonstrate that any medical society may be on dangerous ground if it denies membership to physicians, disciplines members, or threatens to do so because they render services for prepaid plans, including closed-panel plans. In certain circumstances such action might violate the Sherman Antitrust Act if interstate commerce is involved, or might violate state constitutional provisions and other laws relating to restraints of trade. Legal counsel should be consulted before action is taken which may affect a prepaid plan or physicians affiliated with it.
6. Court decisions show that conflict between some of the principles of medical ethics and some aspects of a plan's operation does not automatically justify screening applicants or disciplining members because they work for the plan. Courts have held, under the circumstances of particular cases, that societies were not justified in taking action against physicians who worked for closed-panel plans in which patients did not have free choice of physician, physicians were not compensated on a fee-for-service basis, and the plan advertised and solicited members or subscribers without misrepresentation or improper conduct.
7. These cases do not hold that these ethics or other ethics in certain circumstances do not justify action regarding membership, even though a prepaid plan may be adversely affected. Although there are no decisions under the antitrust laws involving the point, a court might well hold that false and misleading advertising and solicitation, extolling of physicians, interference by laymen in the treatment of patients, and inadequate medical care might be justification for medical society action in particular situations but the evidence would have to be clear and convincing. Whether the society's action is justified will depend on appraisal of all pertinent facts with a view to determining whether the society's action is aimed at protecting the quality of medical care, the patient-physician relationship, the standards of the profession, and the like or instead is calculated to restrain a legitimate business. Equally dangerous as exclusion from membership are any other coercive activities designed to restrain a medical care plan. The dangers of screening applicants or disciplining members in certain circumstances because they work for a closed-panel plan, should not cause a society to conclude that membership must automatically be granted to a physician simply because he works for a plan.

8. There are certain other well-recognized areas of lawful activity available. A medical society may lawfully and properly use education, persuasion and cooperation in an effort to eliminate the evils or dangers which a society believes exist, and activities of this nature have been utilized both at the national and local levels over many years. Competition is also available if physicians object to the manner in which a particular plan in the community is operated. They may encourage the development of plans and the expansion of coverage to meet competitive situations. A medical society and members of the medical profession may also properly present views to the legislature concerning the structure, method of operation, relationship with physicians and other facets of particular plans, for the purpose of obtaining legislation to protect the public and the profession, or for the purpose of opposing legislation deemed detrimental. However, activities, otherwise lawful, may become unlawful if they are part of a conspiracy to restrain trade. Prepaid health plans sponsored by medical societies or by groups of physicians, and perhaps physicians unaffiliated with any plan, are equally entitled to the protection of laws relating to restraints of trade and interference with business, as a result of any activities of other prepaid plans. Whether in any given locality any prepaid plan in its method of operation is or will be unlawfully restraining trade can only be determined by a careful analysis of the operations of that plan. If interstate commerce is not affected, applicable state laws will have to be considered.

D. CONCLUSIONS CONCERNING THE OBJECTIVES OF THE COMMISSION

The following conclusions relating to the broad objectives of the Commission are based on the personal observations of the members of the committee. These opinions concerning the questions posed by the Commission are necessarily based on the information available to the committee. The members of the committee believe these opinions are sustained by their individual knowledge, judgment, and experience.

The following answers should be construed as more concise statements of the detailed listing of conclusions found in Parts A, B, and C of this section. They are to be read and considered in the light of, and in conjunction with, the more specific conclusions previously enumerated.

1. What are the effects of these plans on the quality of medical care?

Based upon its observations, the committee believes that the quality of medical care rendered to subscribers by the units visited and, within the scope of services offered, is comparable to the average level of care which members of the committee have observed in their years of medical practice.

The quality of medical care has improved for many low income groups now covered by these plans since a considerable number live under conditions that have made the procurement of medical care a difficult problem.

The lack of continuity in medical care, which occurs in varying degrees in conventional medical practice, is an ever-present problem in the provision of medical service through such plans. Fragmented care and lack of personal follow-up characterizes a number of representative plans observed in operation. It appears in varying degrees and takes different forms, depending upon the type and scope of medical services provided by the individual plan.

2. What is the effect of these plans on the quantity of medical care?

The committee believes that these plans have increased the quantity of medical care received by the segment of the population served by them. Many plans supply medical care to groups of people who would otherwise find it very difficult or inconvenient to obtain medical care, and to many people who have not been educated to seek such care.

The committee saw considerable evidence of "preventive medicine" in the way of screening programs for the early detection of syphilis, diabetes, tuberculosis, parasitic infections, cancer, and some other chronic diseases, and of educational efforts to encourage members to utilize the services available. However, the "preventive medicine" aspects of these programs, which their proponents contend are inadequately provided for by conventional medical practice, have been exaggerated by some of these plans in that such services do not prevent persons from getting sick. Also, in spite of efforts on the part of the plans to encourage beneficiaries to present themselves periodically for examination for the early diagnosis of disease, the plans are utilized, for the most part, by members for diagnosis and treatment when symptoms of illness appear.

3. Does the introduction of a third party in the patient-physician relationship tend to disturb it and result in an inferior quality of medical care?

The introduction of a third party in the patient-physician relationship changes it but not necessarily in such a way as to result in an inferior quality of medical care. Whether or not it does depends upon (a) what relationship existed before the introduction of a third party,

and (b) a balance of the advantages and disadvantages noted later.

The addition of a new and important factor to any situation changes it. Many of the people now covered by the miscellaneous and unclassified plans visited did not have a personal physician. For these groups the introduction of a third party has resulted in more and better care for the following reasons: (1) through such prepayment plans it is easier for people in these particular lower income groups to defray the cost of good medical care; (2) people largely in the lower social and educational levels either in crowded industrial areas or in remote regions where medical care was not readily available or sought are being educated to seek medical care; (3) the plans insist upon a high grade of training for those physicians providing specialist services and their work is closely and critically scrutinized.

If such plans were extended to other groups of patients, who are cared for by competently trained physicians, who can afford to pay for their medical care, and who are educated to the value of seeking it early in the course of illness, these plans would be neither desirable nor advantageous.

The introduction of a third party may then be advantageous or disadvantageous depending upon a balance which exists in any particular plan among the following factors. The main advantages are: (1) the physician is free from concern over administrative and financial considerations involved in patient care and (2) high qualifications for the performance of specialized work are required.

The disadvantages are: (1) the flexibility in meeting the patients' needs cannot be as great because of necessary rules and regulations which are inherent in the administration of these plans; (2) the ever-present possibility that arbitrary decisions might be made by lay boards and administrators which are contrary to the provision of good quality medical care; (3) the likelihood that, due to inertia, necessary changes in procedure or equipment will not be accomplished expeditiously; (4) that by the very presence of a third party the physician bears some responsibility to it as well as to the patient; hence, the physician whose income does not depend solely upon satisfying a patient's needs may not be so responsive to them; (5) if, because of the policies followed by some plans, the patient becomes aware that his physician must look to others for direction and supervision as to the scope of care to be provided and as to procedures to be followed in providing it, the physician may lose prestige and dignity in the eyes of the patient and this may disturb the patient-physician relationship.

The patient-physician relationship need not be so disturbed if these factors are recognized, guarded against and successfully overcome.

If these plans were extended to cover a large proportion of the population so that most physicians found it mandatory to practice in them, the committee believes that many individuals with potential for making valued contributions to medicine would be deterred from entering the medical profession. It is thus likely that an ultimate adverse effect on the quality of medical care could result.

4. Will the plans encourage the corporate practice of medicine, especially by hospitals?

The committee believes that constructive comments on this subject require further elaboration of the phrase "corporate practice of medicine" for the reason that it has been used, as indicated in the section dealing with Laws Relating to Miscellaneous Type Plans, to describe various types of arrangements for medical care. In addition, the question above also is expressly applicable to hospitals as well as to arrangements concerning prepaid medical care plans. As applied to hospitals, many physicians have used the phrase "corporate practice of medicine" to refer to hospitals hiring physicians to render medical services with the hospital receiving the fees. The committee has interpreted the question, "Will the plans encourage the corporate practice of medicine, especially by hospitals?" on the assumption that the Commission would like to know whether prepaid plans studied by the committee will encourage the further development of closed panels and the use of employed physicians by plans and hospitals.

A characteristic of the prepaid direct service plans is the establishment of facilities with closed panel staffs. In some instances, plans own and operate their own hospitals. In at least one instance, the physicians are employed by the hospitals, and in others the financial arrangements are between the physicians and the plan.

If the provision of medical care by a closed panel of physicians through a third party mechanism is one form of so-called corporate practice, then the successful operation of the plans under study by the committee could well encourage the so-called corporate practice of medicine by hospitals.

5. What is the proper relationship between the medical profession and all third party mechanisms?

The medical profession should assume a judicious, tolerant, and progressive attitude toward developments in the medical care field. The need for continued experimentation is recognized, and the profession should undertake, and actively participate in, the study and development of various mechanisms for the provision of medical care of high quality.

medical society approved plans, including blue shield, and private insurance programs

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I. ORIGIN AND DEVELOPMENT OF THESE PLANS

Reportedly, the earliest forms of voluntary medical benefit "insurance" in this country were those offered through mutual benefit associations, employee benefit associations, and fraternal societies. Some of these date back to 1851, and others claim dates of origin of 1854, 1860, etc. In many instances these earlier efforts were developed for the benefit of employees of certain industries which might be geographically isolated. There were also organizations centered around religious and nationality groups at about the same time. For the most part their primary interest was providing financial assistance in the event of death or disability, but many of them made provision either for the payment of health care expenses or for professional services.

Some of the present-day legal-reserve insurance companies were organized originally as employee benefit associations or fraternal societies.

Other committees of the Commission have treated in greater detail the benefit programs now being offered to the public by entities other than medical society plans and private insurance companies. The employee, mutual, and fraternal programs are mentioned here solely as historical background.

Although health insurance in varying forms was offered earlier, the period between 1930 and 1940, following closely after the depression, witnessed developments that resulted in its widespread growth. It was during this period that the medical profession in California, Michigan, and western New York initiated professionally approved programs to assist in financing some of the more costly aspects of health care. That these three geographically separated programs were initiated at about the same time suggests that this subject was receiving serious consideration generally rather than because of conditions in a particular area or of problems peculiar to any one industry or special interest group.

Insurance companies are credited with having offered surgical expense benefits as early as 1903.[27] It is said that the first successful attempts of this sort were accomplished by adding these benefits (presumably by rider) to individual insurance policies. These offerings, however, did not receive much public response, since wage-continuation benefits from disability or loss-of-income insurance were considered more important. The introduction of group insurance in 1911 may have helped set the stage for the later phenomenal growth in the broad field of health insurance.

Another precursor of the widespread activity between 1930 and 1940 was the development of several local plans in the state of Washington. In 1917 one of the county plans in that state was incorporated, although there had been previous activity on a less formal basis.

The plans in that vicinity had a rather complex beginning, developing largely from contract practice as then conducted by interests identified with lumbering, mining, and railroad companies. For the most part, those plans were created to cope with problems peculiar to the area. In 1913 a statewide coordinating agency was formed in Washington when the local plans became involved in underwriting risks which might result in claims originating within the state but outside the area normally served by a local plan. This earlier activity in the Pacific Northwest received relatively little notice outside that area until programs had been launched in other places.[28]

Although many factors may have contributed to the rapid growth of voluntary health insurance after 1940, one source [29] indicates that the interest of the medical

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27. *Franz Goldmann, Voluntary Medical Care Insurance in the United States (New York: Columbia Press, 1948).*
28. *Edwin J. Holman and George W. Cooley, "Voluntary Health Insurance in the United States," Iowa Law Review 35:183-208 (Winter) 1950.*
29. *Ibid.*

profession and of hospitals was the most important. Along with the active interest in health insurance and participation by substantial elements of the medical profession came continued development of plans with medical society sponsorship or approval, including Blue Shield. At about the same time the insurance companies increased their interest as well as their offerings, and various governmental agencies made a number of pronouncements.

Prior to this time labor organizations showed relatively little interest in health insurance, since their attention was then centered around hours, rates of pay, and working conditions.

These several developments taking place across the country were observed by the officers and members of the American Medical Association. It was apparent that these programs might influence medical practice and create new problems, as well as solve some problems, in the economics of health care. Recognizing this, the House of Delegates in 1943 created the Council on Medical Service and Public Relations (renamed the Council on Medical Service; the present title was adopted in 1946 upon the creation of a separate Department of public relations) as a standing committee.

This council was given broad responsibilities. Among its specific functions are "to investigate matters pertaining to the economic and social aspects of medical care" and to make available facts, data and opinions with respect to timely and adequate rendition of medical care for the American people . . ."

Shortly after the launching of the first few plans organized either by the medical profession or with its approval, plan representatives attended meetings to discuss the forming of a trade association. With the assistance of the A.M.A., these plans organized the Associated Medical Care Plans, Inc., in 1946. The primary purpose of this group was to serve as a clearing house for information and to supply technical advice to those who wished to formulate programs under medical society sponsorship. This organization has been named Blue Shield Medical Care Plans since 1950. It includes in its membership those plans under medical sponsorship which apply for affiliation and meet stipulated requirements.

In the fall of 1946 several representatives of insurance trade associations met with officials and representatives of the A.M.A. As a result of several conferences the Joint Health Insurance Committee was formed to effect liaison between insurance programs underwritten by private companies and members of the medical profession. Its broad purpose was to provide technical consultation to the profession on matters relating to health insurance and at the same time make available a better understanding of medical practices to those engaged in insurance administration. Over the years that effort underwent changes and resulted in what is now known as the Health Insurance Council, which is composed of members of the insurance industry without specific medical representation.

During World War II wages were frozen by proclamation of the federal government. Moreover, many workers in industry were prevented from changing jobs. Labor organizations then petitioned successfully for the right to bargain for health and welfare benefits without having such employer contributions considered as wage increases. Following those developments, the courts decided in 1949 that employee benefits were within the realm of collective bargaining.[30] It is estimated that from 1945 to late 1955 the number of workers covered by "health and insurance plans" (sic) under collective bargaining increased from less than 1 million to more than 12 million.[31]

Even prior to the more widespread collective bargaining, many employers had voluntarily made health insurance benefits available to workers and their families on a group basis. Then too, many persons not affiliated with or belonging to any special interest group became aware of the advantages of health insurance. The activity and interest of the medical profession, labor organizations, government (including numerous proposals for compulsory tax schemes or socialized medicine), the insurance industry, and others undoubtedly contributed to arousing the interest of the general public.

30. *A Look at Modern Health Insurance (Chamber of Commerce of the United States, 1954); Inland Steel Co. v. National Labor Relations Board, 170 F. 2d 247, cer. den. 336 U.S. 960 (1949).*

31. *Older Workers Under Collective Bargaining, Part II: Health and Insurance Plans, Pension Plans (United States Department of Labor Bulletin No. 1199-2; Oct., 1956).*

II. THE COMMITTEE'S SURVEY

This committee was charged with the specific responsibility of reviewing programs underwritten by medical society and related plans, including Blue Shield, and private insurance programs. In some areas of study the committee was able to combine the discussion of these two broad categories, while in other instances it was necessary or desirable to distinguish them.

Before stating observations and conclusions regarding the various objectives, it may be well to summarize by category the number of plans and the number of persons insured as well as the methods and extent of the surveys employed.

MEDICAL SOCIETY AND RELATED PLANS, INCLUDING BLUE SHIELD

In this classification 116 plans reported approximately 39 million persons insured by the end of 1955 against all or part of professional expense incident to surgical care. One new plan was organized in 1956, and the total surgical benefit enrollment increased to over 42¼ million by the end of that year. Of the 39 million enrolled for surgical benefits at the end of 1955, about 29 million were also entitled to benefits for other professional care. This figure increased to nearly 34 million by the end of 1956. (The slight variation between the foregoing figures and those reported annually by the Survey Committee of the Health Insurance Council is due to different methods of classifying certain plans).

PRIVATE INSURANCE PROGRAMS

The committee attempted to compile a complete listing of all private insuring organizations having the charter power to write surgical or surgical-medical expense benefits for professional care. Although more than 1,400 organizations are apparently authorized to underwrite these risks, the number actually doing so seems to be nearer 500, since most of the insurance reporting services tabulated premium and loss data for approximately 430 companies with respect to hospital, surgical, and/or medical expense benefits and also identified some 95 additional companies as engaged in writing medical expense policies without reporting their premium and loss data. The number of persons insured by these companies against the expense of surgical care was in excess of 56 million as of December 31, 1955. Surgical coverage underwritten by insurance companies increased to almost 63 million during 1956. As of the end of the two years approximately 25 million and 30 million, respectively, were entitled to benefits for professional care other than surgery.†

SURVEY METHODS

Since it is the custom of the American Medical Association to secure and compile data from medical society approved plans through the Council on Medical Service and its Committee on Prepayment Medical and Hospital Service, reports on these plans were available to this committee. Basically, this information includes enrollment figures and summary descriptions of the benefits offered under these programs.

In addition, the Blue Shield Commission was asked what data they might have that would be of interest to the Commission on Medical Care Plans. It was learned that the Blue Shield Commission had compiled information regarding the characteristics of its member plans as well as a tabulation of the amounts of benefits payable for the 29 most commonly reported surgical

†*As this portion of the report is being prepared for publication, the total number of persons reported enrolled at the end of 1957, by all types of voluntary mechanisms, by category of benefit was: Hospitalization—123 million; Surgical expense—109 million; Regular medical—74 million; Major medical and hospital—13 million.*

procedures. The format of this Blue Shield compilation was also used by the staff in seeking data from other medical society approved plans.

With that type of data available, the committee prepared a study outline and submitted it to the Survey Committee of the Health Insurance Council for the purpose of securing comparable data concerning the programs underwritten by private insurance companies. This latter study was divided into two sections: (1) those companies writing group insurance primarily, and (2) those companies which offer their policies principally to individuals and families.

EXTENT OF THE SURVEY

The Blue Shield Commission compiled information related to 64 plans, describing (1) their most liberal policies (those with the best provisions in either scope or extent of benefits), (2) their most prevalent policies (those carried by the greatest number of persons), and (3) the amounts payable under these policies for each of the 29 procedures.

From this information appropriate tables were prepared, and questionnaires based on this format were sent to 38 medical society approved plans which were not included in the Blue Shield study. Approximately half of the plans, representing 86% of the enrollment, supplied detailed information regarding the characteristics of their respective organizations. These responses, like those compiled by the Blue Shield Commission, have been summarized and tabulated in the statistical supplement to this report (Part II, Appendix C).

With respect to the characteristics of the programs of insurance companies, the Life Insurance Association of America, on behalf of the Health Insurance Council, conducted a survey among the group-writing companies. The information gathered through this source represented almost 63% and 70% of the surgical and medical benefits, respectively, of all such insurance companies.

On behalf of the Health Insurance Council, the Bureau of Accident and Health Underwriters (now a part of the Health Insurance Association of America) conducted a survey among both the larger and the smaller insurance companies underwriting individual and family surgical and regular medical expense policies. It is estimated that this portion of the survey accounted for between 40% and 50% of the number of persons covered by companies writing non-group (individual and family) surgical as well as regular medical expense benefits. Again in this instance the data obtained have been summarized in tabular form.

Due to the volume of the data concerning Blue Shield plans, other medical society approved plans, and insurance company programs, this material is included in Part II of this report.

The committee has not considered it necessary to present a detailed analysis of these data. It feels that its contribution consists in the fact that, for the first time, statistics of this nature have been assembled for the benefit of the profession, for all those interested in comparing various types of benefits offered, and for analyses and comparisons to be made wherever deemed desirable.

It is apparent that variations in benefit payments and coverage among various plans do exist. These statistics will have served their purpose if they call attention to characteristics and provisions which some plans may have omitted, or which other plans have sought to include in order to broaden the scope of their programs.

III. PRINCIPLES OF INSURANCE

Because of distortion of the meaning of the term "insurance," some segments of the public have come to expect underwriting carriers to provide coverages which are unsound or improper. Perhaps it would be well at this time to restate the basic principles of insurance, as follows:

1. The risk must be subject to the laws of mathematical probability.
2. There must be an insurable interest.
3. There should be a large number of independent risks spread over a fairly large geographic area.
4. The risk involved must be important to the insured party.
5. There must be an element of uncertainty as to the occurrence of the event.
6. The existence of insurance should not have a tendency to increase the risk or to provide an opportunity for the insured to make a financial gain.
7. The risk must be measurable financially.

In essence, these principles state, respectively, that:

1. It is necessary to be able to predict with a reasonably high degree of accuracy just how often the contingency insured against may occur.
2. The insured must be involved to the extent that he would suffer a financial loss upon the occurrence of the event against which he is insured.
3. A diversity of risks is necessary to reduce the probability that a majority of persons insured under a single program would be eligible for benefits at any one time.
4. If the contingency to be insured against is of little or no financial consequence to the insured, there is little or no need for carrying the insurance.
5. If a person knows in advance that an event is going to take place at a given time, insurance is less appropriate than budgeting so as to be able to meet the loss.
6. The existence of insurance should not result in unnecessary use of health services and/or facilities.
7. The measurement of cost is of extreme importance because of the direct relationship between the benefit payment and the premium.

In applying the principles of insurance to health care costs, the committee believes that the proper function of voluntary health insurance is to alleviate financial distress occasioned by the expenses of necessary health care. It follows that health care costs that are routine, known to be recurrent, inconsequential in amount, and anticipated by the patient should not be insured because the administrative charge for the insurance must be added to the costs themselves. It should be noted, however, that a health care program may ignore some of these principles in order to extend or provide benefits which would not be covered under a program which embodied all of the principles of insurance.

IV. "BASIC" AND "MAJOR" HOSPITAL AND MEDICAL EXPENSE BENEFITS

Enrollment figures have already been given for the numbers of persons protected by agreements with medical society plans and insurance companies. The figures related to those insured primarily against the costs of surgical care (105 million) and medical care (64 million) by the end of 1956, as distinguished from enrollment for hospitalization and related benefits. Moreover, these figures relate to "basic" benefits rather than to the extent of coverage under a newer category of insurance known varyingly as "catastrophe," "major hospital and medical," or "major medical."

The most prevalent type of health care insurance of either the indemnity or service type is commonly referred to as basic. Basic coverage provides benefits according to specified allowances, usually including the entire costs up to the maximum allowance. However, as a method of minimizing unnecessary or improper claims against the insurance fund, the insured may be called upon to pay in addition to the premium an original amount[32] against the cost of the benefit or a stated percentage[33] of the total cost, the insurance providing the balance up to the agreed allowance. Certain types of services are often excluded from benefits in order to assure an economical and sound insurance operation.

A recently introduced form of contract for health care protection is called "major hospital and medical" insurance. This form provides for comparatively large aggregate dollar limits for expense of hospital, medical, and related care, usually without limitations on specific cost items. Aggregate limits of $10,000, $15,000 and $20,000 are not uncommon. In order to protect the insurance against unjustified claims, comparatively high deductibles and co-insurances are incorporated. This major medical insurance is often used to supplement basic coverage for maximum protection. However, a marked trend toward reduction of the deductibles and the co-insurance has been observed, which may result in the substitution of this form for the basic type in many cases.

Like the basic insurance plans, the origin of major medical insurance was modest in comparison with the estimated total of 13 million persons insured since it was first offered generally in 1951. To some extent special risk policies providing reimbursement of substantial sums for the cost of treating poliomyelitis and other dread diseases may have been a beginning. However, the original experiment with major medical insurance as it is now generally written was confined to approximately 2,200 employees of an organization willing to cooperate with an insurer for the purpose of gaining data and experience. The experimental group was relatively homogeneous as to employment, age, sex, and income. In 1949 the initial experiment was limited to members of the group. Dependent coverage was offered the following year, and subsequently all other employees of the organization were permitted to participate.

During this period, other insurers were developing cost data from among their own employees and from other sources in anticipation of entering this new type of underwriting.

The application of deductibles and co-insurance as well as the exclusion of certain benefits in these newer and broader forms of insurance is intended to control utilization and to reduce premium costs. These techniques, of themselves, are effective only to a limited degree. While insurance creates no new wealth with which to pay for health care, it may in the individual case offer a temptation to the providers of service to increase charges. The insured's resistance to such increases is perceptibly weakened by the fact that he is personally relieved of the immediate effect unless the coverage contains adequate deductible and co-insurance clauses.

The foregoing chapters are admittedly only a summary. They are intended to serve as a basis for answering the specific questions set forth in the objectives of the Commission.

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32. *In insurance parlance this is referred to as the "deductible." It means that the insured person must spend (or become obligated for) a certain amount before a claim is charged against the insurance fund. The deductible is usually expressed in a specific dollar amount. Its purpose is to relieve the insurance mechanism from the cost of administering small items of expense and thereby to conserve the insurance fund for losses of greater financial significance which would otherwise be an undue burden to the insured or his family.*

33. *The specified portion of the loss which the insured person assumes is called co-insurance. Although co-insurance and the deductible are separate features, both are often contained in the same insurance agreement. The purpose of co-insurance for health care is to provide the insured person a continuing as well as an effective financial interest in the costs incurred and to reduce demands for unnecessary services. Both the deductible and co-insurance clauses reduce the premiums.*

V. CONCLUSIONS

THE NATURE AND METHODS OF OPERATION OF THE VARIOUS TYPES OF PLANS

Medical society plans.—Plans with either medical society sponsorship or approval include those which were incorporated under special enabling legislation and those formed under general statutes of the various states or, in several instances under the provisions of state insurance codes. In at least two instances such plans are not separate corporate entities but are agencies or extensions of the medical society.

The methods of operation vary, but in general medical society plans are administered as insurance organizations. Sales methods also vary, but for the most part these plans make their offerings to the general public through salaried representatives.

Private insurance programs.—The corporate entities offering private insurance include companies organized on a capital-stock basis, non-assessable (general) mutual companies, assessment mutual and cooperative assessment companies, and fraternal benefit societies. Thus, the so-called corporate nature of these organizations varies widely, as in the case of medical society plans, without any significant set of characteristics necessarily being applicable to all.

These companies employ both salaried sales representatives and representatives who are paid in proportion to their volume of sales.

It is the understanding of the committee that this Commission objective required only statements of fact. In view of this, the committee has observed that in general there are relatively few marked differences in organization or operation between the two general categories of plans within its purview. It is recognized that management is selected in mutual insurance companies by the policy holders, in stock insurance companies by the stockholders, and in most instances of medical society approved plans by the sponsoring society.

By way of further explanation, most mutual insurance companies utilize salaried sales representatives in much the same manner as do plans organized or approved by medical societies. Moreover, in some instances medical society plans using the sales agencies of other organizations, such as hospitalization plans, may be charged sales costs in proportion to the amount of business written.

As they are now constituted, both medical society plans and private insurance programs are mechanisms available to the general public by which funds can be pooled to assist in the financing of health care.

THE EFFECT OF THESE PLANS ON THE QUALITY AND QUANTITY OF MEDICAL CARE

Most of the observations of the committee regarding this objective of the Commission apply equally to both medical society plans and insurance company programs. Since these plans provide financial assistance to the insured rather than medical care itself, they do not appear to have a direct effect on the quality of the care.

It is most difficult, however, to ascertain the extent to which these plans have an influence on the quantity of professional care. Undoubtedly, the existence of voluntary health insurance has resulted in an increased demand for treatment. Since voluntary health insurance is only one of the factors in an expanding and somewhat inflationary economy, the extent to which insurance in and of itself affects the quantity is difficult if not impossible to measure. While we realize that it has had its effect on increased demand for treatment, we cannot measure that effect.

Insurance undoubtedly encourages timely health care because it either reduces or eliminates any financial barrier. It is apparent, moreover, that voluntary health insurance has materially reduced the number of people who find it difficult to pay for medical care.

THE LEGAL AND ETHICAL STATUS OF THE ARRANGEMENTS USED

This aspect of all medical care plans has been treated by the committee appointed to review the laws of the various states and the actions of the Judicial Council in interpreting the Principles of Medical Ethics.

It is presumed, however, that all of the medical society approved plans as well as all insurance companies have appropriate legal status. This is by virtue of the fact that most of them have been organized under the appropriate laws of the state in which they were incorporated and are, moreover, accountable to one or more state regulatory or supervisory authorities.

It has come to the attention of the committee that some plans apportion a benefit if a policyholder or subscriber is treated by more than one physician. This is especially true in some of the plans which provide benefits only for surgical procedures. In some instances a physician other than the surgeon will manage a case before and after surgery. If the benefit is for a surgical procedure only and does not include preoperative and postoperative care, and if the plan allocates a portion of that benefit for either preoperative or postoperative care or both, the propriety of this activity might be subject to question. It is the opinion of the committee that any action on the part of a plan or an insurance company which would result in an allocation of a benefit contrary to the provisions of the insurance contract would constitute an undesirable practice.

1. What effect, if any, do these plans have on the traditional patient-physician relationship?

If all arrangements for the insurance are limited to the subscriber and insurer, and if all medical relationships remain exclusively between the patient and his physician, then the insurance program has no effect on the traditional patient-physician relationship.

On the other hand, if a benefit is payable only in the event a subscriber receives care from specified physicians, or if a benefit otherwise payable would be reduced if health care were not sought from a specified list or group of physicians, then the insurance program might have a very definite effect on the traditional patient-physician relationship.

In other words, the extent to which any insurance program influences the traditional patient-physician relationship can be gauged primarily by the extent to which the insurance agreement limits methods of treatment or absolute free choice of physician at the time of seeking health care. If no arbitrary provisions are contained in an insurance program, then it can be assumed that the program will not affect the traditional relationships.

2. Does the introduction of a third party in this relationship tend to disturb it and result in an inferior quality of medical care?

In the opinion of the committee there is no disturbance of the patient-physician relationship, and these plans, as they now exist, do not result in an inferior quality of medical care.

3. Are there plans in which the participating physician is violating the Principles of Medical Ethics?

The relationship of the physician to these plans does not promote the violation of medical ethics. It is generally conceded that the Principles of Medical Ethics apply equally to all physicians irrespective of the manner in which they practice. In other words, a physician is expected to comply with these principles whether he practices alone, as a partner, or as a member of a group or clinic. His affiliation with others, if any, relieves him of none of his responsibilities which are inherent in medical practice.

4. Will the plans encourage the corporate practice of medicine, especially by hospitals?

If a plan (incorporated or not) should undertake to provide medical care as distinguished from assistance in financing such care in whole or in part, such an undertaking would convey the erroneous impression that the plan had the ability to render medical care. Only a human being (natural person) is capable of satisfying the legal and educational requirements for a license to practice medicine.

In several instances a medical benefit program is sold and administered either together with or as an extension of a hospitalization benefit plan. When the medical plan does not include benefits for certain professional services and the hospitalization plan does provide payment for services of a professional nature which are improperly classified as hospital services and payment for such services is conditioned upon being rendered by an employee, then there is no question that such a program—if offered by a corporation—would encourage the corporate practice of medicine. This would be equally true of a hospitalization program sold or administered independently of a medical benefit plan.

The committee is of the opinion that classification of professional services as hospital services is improper and not in the public interest.

In general, whenever any insurance plan or program underwritten by an incorporated body tends to dictate the methods and manner by which medical care is provided, such activity could be construed as encouraging the corporate practice of medicine.

Because of the foregoing and the fact that qualifica-

tions for medical licensure and practice can be satisfied only by a natural person, the committee believes that a distinction must be made between programs which purport to provide medical care and programs which assist in the financing of medical care. The committee believes that the latter is the only† proper function of a medical care program, whether organized as a corporation, trust, association or partnership.††

5. What is the proper relationship, if any, between the medical profession and these third-party financial mechanisms?

The relationship between the medical profession and insurers should be one of free and sympathetic cooperation without prejudice or bias. It is recognized that component medical organizations may sponsor or operate health-insurance mechanisms. However, individual physicians should assume the responsibility of cooperating with all recognized and proper methods of insuring health care costs, should assume the responsibility of being informed, and should advise and encourage their patients and the public in the proper evaluation and utilization of such methods.

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†Dr. Conway comments: Unquestionably, the committee sincerely believes this statement, and hence, as worded, the statement is undoubtedly correct. However, I believe that the *principal* function of a medical care plan is to assist in the financing of medical care. "Only" is exclusive. Trustees of a fund can build a very strong case for the position that they have a responsibility to see that the product for which money is expended is of good quality. "Only," in my opinion, if the medical profession assumes and discharges the responsibility for quality of care can the statement, as made, be upheld.

††Dr. Price comments: Here, I should like to point out that this statement deals specifically and solely with the Blue Shield and other types of medical society approved plans as well as with commercial insurance. This statement does not refer to the group of plans in the Miscellaneous and Unclassified category which, in many instances, are service oriented.

However, plans providing service benefits are now not only popular but in great demand among industrial groups. It is my feeling that if Blue Shield plans are to compete with those of the service oriented programs in the Miscellaneous and Unclassified category, the former must initiate and expand service benefits and educate all physicians in the need for participating in their provision.

If the reader would refer to the valuable experiments now being conducted by some Blue Shield plans listed in Part II of the Commission's report, he would find that the medical profession not only has the means at hand to offer medical care through service programs but has made a beginning in offering service benefits to the population. Such a broader and enlarged development would help meet the needs that are now being acknowledged by newer forms of medical practice.

The growing public consciousness in the costs of surgical, medical, laboratory and other diagnostic services demands that people be adequately informed of the full costs of such services and the basis upon which they are determined. Therefore, the adoption of relative value schedules throughout the country, which actually would serve as a basis for the establishment of fee schedules, may well provide the patient and the medical profession with an acceptable solution to some of the problems discussed by this committee. The present indemnity benefit schedules, as distinguished from service benefits, are frequently misunderstood by many people because such indemnity schedules often imply that they are full, or reasonably full, payment for procedures. In effect, however, they represent only partial payments since the actual charge is determined through arrangements between the physician and the patient. The disturbing feature is that this information is acquired by the patient in too many instances only after the medical services have been rendered. The important topic of relative value schedules is, I understand, presently being studied by another committee of the American Medical Association. Its results are being awaited with great interest.

VI. ADDITIONAL OBSERVATIONS

The committee discussed many aspects of these programs with regard to their over-all philosophy as well as their specific coverage. The committee feels that certain of these aspects should be emphasized, since several of them may have bearing on other mechanisms within the province of the Commission.

PROFIT VERSUS NON-PROFIT

A great deal is spoken and written about the relative virtues of profit and non-profit organizations in the health-insurance field. With respect to this, the committee believes that whether a plan is professedly organized for profit or not seems to have little effect on its inherent ability to provide sound, adequate insurance. Nor does this characteristic exert a discernible influence on the proper practice of medicine. The profit motive is the wholesome driving force of private enterprise. In health care, profits developed out of the operation of the plan may be returned either to stockholder-owners in cash dividends or to policyholder-subscribers as lower insurance costs or expanded benefits. Sponsors and organizers of such plans receive an indirect benefit from their operation to the degree that private practice of medicine is preserved.

The open, free, and keen competition among all types of voluntary health insurance is in the public interest. Such competition engenders experimentation, looking toward improvement in coverage, cost, and availability. It stimulates widespread adoption of such improvements.

SERVICE VERSUS INDEMNITY

The relative advantages and disadvantages of service (full payment) and indemnity (specified allowances) are also discussed often and with intense feeling. Each type of program has certain features and characteristics which make it attractive for various reasons to different groups. With regard to this, the committee believes that both service and indemnity plans are based on insurance principles. The distinguishing feature of the service type of plan lies in the contractual fee-for-service arrangements between the plan and the providers of the services. It is not impossible that similar arrangements may be made between indemnity plans and the providers of health services, thus in effect accomplishing the same result. Conversely, service plans employ the indemnity approach under some circumstances and with respect to some benefits.

Insurance against the cost of health care should not be confused with the purchase or rendering of care. Indemnity and service plans both undertake at stipulated rates to provide certain benefits, usually limited by dollar amounts, under certain conditions. Some organizations often called insurance plans are in reality not risk-bearing undertakings but arrangements whereby their members employ professional personnel and either contract for or own and operate hospitals to render covered services. The employment of personnel is usually on either a salary or capitation basis.

INFLUENCES OTHER THAN INSURANCE AND MEDICINE

In any appraisal of the ability of insurance to fulfill its proper function in alleviating the distress of the costs of health care, consideration must be given to influences outside the insurance programs and the medical profession. To do this it is essential to analyze the demands sometimes made of the insurance mechanisms.

There are special interest groups (both governmental and non-governmental) which propose unrealistic goals. These may be proposed intentionally or because of a lack of appreciation of the true function of insurance. Because health and health care are often highly subjective, the financing of such care often involves a high degree of emotionalism unless caution is exercised in facing realities. This applies not only to a consideration of the sources of health care, but to the responsibilities and philosophies of the recipients as well.

In other quarters, including some echelons of government, programs proposed in the name of insurance may contain elements which are incompatible with the well-established fundamentals of insurance.

It should perhaps be repeated frequently that insurance is a financial mechanism—a means rather than an end-result—in the realm of health care financing. To

refer to it as anything more or less is unrealistic. Moreover, such activity, whether intentional or otherwise, renders a disservice to the insurance mechanisms and to those who are insured as well as to those who contemplate such coverage.

The existence of an insurance plan cannot in and of itself create professional personnel nor guarantee the availability of health care. In the final analysis, only physicians, together with ancillary professional and technical personnel, are competent by law, education, and training to render such care.

ORGANIZATIONAL CONTROL AND RESPONSIBILITY

From time to time medical society plans and certain insurance companies are criticized on the broad assumption that they are controlled by special interest groups or because the subscribers or policyholders are not specifically represented on the governing board. The committee believes that voluntary insurance should be controlled and operated by those who bear the responsibility for its success. Thus, representation on governing boards or in management by those who are without accountability for the results of the enterprise contributes nothing and can be an obstacle to successful development. The importance and intimacy of health services are such that control without responsibility can lead directly to concentrations of authority that are alien to the public interest. Organizational control both of voluntary insurance and of the actual provision of service should be restricted to those who have a real responsibility for the success of the function that they direct.

MERIT RATING

There are two general methods of calculating premium charges for insurance coverage. One is known as community rating and the other is sometimes referred to as merit rating. The former applies the same basic rate to all persons or groups within a given jurisdiction. That is, all groups pay the same premium for the same contract coverage without regard to such differences in the composition of the various groups as age, sex, or type of industry. The merit-rating approach tends to classify groups according to their inherent characteristics as refined by their claim experience. In other words, if one group experiences lower losses (less claim costs in relation to premium payments) within its membership than another, this better-than-average experience may be reflected either in a rate credit or in a lower premium rate. Since the very nature of insurance is in risk assumption and the pooling of funds, the committee believes that the practices of the insurer must not unfairly discriminate against any group in total insurance costs. Conversely, the insurance charge must fairly discriminate among risks by reflecting with reasonable accuracy the risk transferred to the insurer. Merit or experience rating applied to preferential risks must be used with restraint.

DUPLICATE COVERAGE

For a large number of persons there is ample opportunity to become insured concurrently under several types of programs. This is especially true in those instances where both husband and wife are gainfully employed. Each may have the opportunity to become the primary insured at the place of employment and include the spouse and children as dependents. Above and beyond this, there are many opportunities to buy supplemental insurance on an individual basis or to participate in other than employer-employee group programs by virtue of membership in organizations. This can frequently result in what is known as either duplicate insurance or over-insurance. This problem is recognized particularly by those who are engaged in health-insurance administration as well as by those in the health professions. The committee decries as inimical to the public interest issuance of duplicate coverage or over-insurance that permits the insured or provider of service to profit from disability.

CONTINUING RESPONSIBILITIES

Preservation of the fee-for-service principle and of freedom from third-party interference depends upon a universal recognition by the individual providers of health service of their moral responsibility to charge fees based upon the intrinsic value of service rendered and not influenced by the existence of any mechanism for the financing of health care costs.

The development of the unallocated-expense types of health insurance re-emphasizes the responsibility of the providers of service to safeguard against abuse, extravagant utilization, and unnecessary procedures that would raise the total burden of health care. Inflation of health care costs, particularly when attributable to such practices, could well lead to imposition of third-party controls.

These points have been recognized by the American Medical Association on previous occasions and were well stated in a report of the Council on Medical Service adopted by the House of Delegates during the 1954 Clinical Session, when this Commission was created. It seems appropriate to include the following excerpt from the 1954 statement:

> . . . It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose.

industry programs

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INTRODUCTION

At the April, 1956, meeting of the Commission on Medical Care Plans, the Committee on Industry Programs reported on the need for a clear statement of desirable objectives, scope, facilities, and personnel requirements of occupational health programs by some agency of the American Medical Association. Such a statement was considered necessary, following the committee's studies of industry programs, which are discussed later in this report, to supplement the "Guiding Principles for Evaluating Management and Union Health Centers" which had been approved by the House of Delegates in Boston on December 1, 1955.

Both the Commission and the Board of Trustees concurred in the committee's recommendation, and the Council on Industrial Health was asked by the Board of Trustees to prepare such a statement. The statement, entitled "Scope, Objectives, and Functions of Occupational Health Programs," was adopted by the House of Delegates at the Annual Meeting in New York on June 6, 1957. In recommending the adoption of the statement by the House of Delegates, the Reference Committee on Hygiene, Public Health, and Industrial Health stated[34]:

> It is the unanimous opinion of your reference committee that the House has before it a statement which for the first time clearly defines the scope, objectives, and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine, and it clearly charts the pathways of communication between physicians in occupational health programs and physicians in the private practice of medicine.

Almost every practicing physician is in some way part of occupational health. Whether directly, through contractual association with an industrial organization, or indirectly, through the diagnosis and treatment of an employee or a member of his family, the physician must be aware of all aspects of occupational medicine. Probably the most important conclusion that can be drawn from the committee's report of its study of medical care programs in industry is the recommendation that the local medical society be consulted to assure that the given program of "occupational medicine" is in agreement with the established community practices.

In view of the importance of this statement and its bearing on the committee's work, it is here reproduced in its entirety as the next chapter of this report.

34. *"Occupational Health Programs" (Proceedings of the New York Meeting, June 3-7, 1957), J.A.M.A. 164:1104 (July 6) 1957.*

I. STATEMENT ON THE SCOPE, OBJECTIVES, AND FUNCTIONS OF OCCUPATIONAL HEALTH PROGRAMS[35]

INTRODUCTION

As used in this statement, the term "occupational health program" means a program provided by management to deal constructively with the health requirements of employees and employers in relationship to employment.

The term "occupational medicine" means that branch of medicine practiced by physicians in meeting medical problems and needs under occupational health programs.

Occupational health programs in the United States stem from the medical services established by some employers in the middle of the 19th century to meet the needs of their employees in locations where medical services were not satisfactory or readily available. Further impetus to their development was given by the enactment of laws in various states which obligated many employers to maintain safe and healthful work environments and to compensate employees for occupational disability or death.

OCCUPATIONAL HEALTH PROGRAMS

Although health maintenance is primarily the responsibility of the individual, an occupational health program represents management's recognition of its obligation to provide a safe work environment and its opportunity to promote better health among its employees. While circumstances may affect the extent of certain services which may enter into a comprehensive health program, a high quality of performance must be preserved at all times.

Cooperation between physicians, nurses, industrial hygienists, technicians and other personnel of the occupational health program and management personnel responsible for the employment, safety and well-being of employees is essential. Occupational health personnel should cooperate also with private and official community agencies providing health, safety, employment, and welfare services.

Through the years many forms of occupational health programs have been developed from which has emerged an acceptable basic pattern. Experience indicates that success can best be assured when:

1. The program
   (a) Observes the basic principle of service to the individual by a physician and conforms to medical customs in the community.
   (b) Complies with existing laws.
   (c) Emphasizes prevention and health maintenance.
   (d) Utilizes community medical resources when adequate or when they can be developed reasonably.
2. The physicians participating in the program
   (a) Maintain high standards of professional service and conduct for the benefit of employee and employer alike.
   (b) Cooperate and maintain proper liaison with other physicians in the community and with the local medical society.
   (c) Are engaged and compensated in accordance with the Principles of Medical Ethics of the American Medical Association.
   (d) Do not use their occupational health affiliations as a means of gaining or enlarging a private practice among employees.

In recent years, with the recognition by employers and employees of the values attainable through occupational health programs which apply the advances in preventive medical and engineering knowledge, the earlier concept of curative occupational medicine has

35. *"Scope, Objectives, and Functions of Occupational Health Programs," ibid., pp. 1104-1106.*

been broadened to include and emphasize prevention and health maintenance.

Although current programs reflect varying degrees of development, they all provide a common opportunity for employers, employees and physicians to carry on adult health programs which supplement other health services available in the community and which serve as effective components in community health.

From time to time, problems arise out of a misunderstanding of the proper scope of occupational health programs as contrasted with medical programs for personal (non-occupational) illness of employees. It is, therefore, essential that employers, employees, and physicians recognize the fundamental distinction between these two types of programs.

In general, these two kinds of programs differ in objectives, methods of financing, amount and type of service provided, and, in some cases, in the composition of the group covered. Although the same medical personnel may serve or administer both types of programs, certain activities of occupational health programs are not appropriate to, and cannot generally be performed successfully within the framework of, personal medical service programs. The occupational health programs must be oriented to the work environment and to the health of the employee in relation to his job. On the other hand, when service rendered by physicians under occupational health programs exceeds the limits described hereafter, the occupational health program becomes to that extent a medical program for personal illness and should be so recognized by all concerned.

MEDICAL PROGRAMS FOR PERSONAL (NON-OCCUPATIONAL) ILLNESS

These programs owe their existence to certain factors and circumstances in the employer-employee relationship not directly related to occupational health considerations. A major objective of such programs is to distribute the cost of medical service so as to lighten the economic burden on the employee. Some programs include dependents and/or retired employees as well as the employed group. They are usually designed to provide medical, surgical, and hospital care. The cost of such programs may be financed jointly or solely by management, unions, or the subscribers. Medical services may be provided by personal physicians, or by physicians in management or union health centers, or by other physicians upon referral. Such personal medical services may be diagnostic, therapeutic, or rehabilitative, and may be limited or comprehensive in scope. These programs are separate and distinct from occupational health programs, the objectives, activities, facilities, and personnel of which are described in the remainder of this statement.

OBJECTIVES OF OCCUPATIONAL HEALTH PROGRAMS

The objectives of an occupational health program are:

1. To protect individuals against health hazards in their work environment.
2. To insure and facilitate the placement and suitability of individuals according to their physical capacities and their emotional make-up in work which they can reasonably perform with an acceptable degree of efficiency and without endangering their own health and safety or that of their fellow employees, and
3. To encourage personal health maintenance.

The achievement of these objectives benefits both employers and employees in terms of improved employee health, morale, and productivity.

ACTIVITIES TO ATTAIN OBJECTIVES

In order to attain these objectives the following activities (and the maintenance of appropriate records) are essential:

1. Supervision of the work environment from a health standpoint.—This requires periodic inspections by physicians of the entire premises used by employees, including provision for, and appropriate participation in, the procedures and tests required to detect and appraise health hazards. Such inspections and appraisals provide current information on health aspects of work conditions, processes, and substances used. This information, including those relating to stress and mental health, will aid in evaluating any health hazards that may exist and in making appropriate recommendations for preventive or corrective measures.

2. Health examinations.—Unrealistic and needlessly stringent standards of physical fitness defeat the purposes of health examinations and of maximum utilization of the available work force.

Health examinations should consist of:

(a) An initial examination to determine the health status of the individual in order to facilitate suitable placement in employment. This examination should include (1) his family and personal medical history, (2) his occupational history, (3) a physical examination, and (4) other procedures to help determine the individual's employability and his capacity for work.

(b) Subsequent examinations carried out at suitable intervals and designed to detect any sign or symptom of ill health related to employment conditions and to evaluate the health status of the individual in order to determine whether his health is compatible with his job assignment.

All examinations must be conducted by physicians with such assistance from ancillary personnel as may

be required. Prior to each examination, the individual should be advised as to its constructive purpose and value. At the conclusion of an examination, the physician should discuss his findings meaningfully with the individual. When health defects are found, the physician should explain to the individual the importance of obtaining further medical attention, and encourage him to consult his personal physician.

3. Medical records.—The maintenance of accurate and complete medical records of every individual from the time of his first examination or treatment is a basic requirement. Except when otherwise required by law, the confidential character of these records, including the results of health examinations, must be rigidly observed by all members of the occupational health staff, and such records must remain in the exclusive custody and control of the medical personnel. The patient should be informed of all pertinent health findings except when such disclosures would have an adverse effect on his health and well-being. A private physician or other agency may be provided with a report of health findings when the patient so designates. Disclosure of health information should not be made without the approval of the patient except when essential to fulfill the legal obligations to the third party or to the public, and then only to the extent necessary to fulfill such obligations.

4. Medical diagnosis and treatment.—Every employee should be encouraged to have a personal physician.

(a) Diagnosis and therapy required by workmen's compensation laws for occupational injury or illness should be directed toward optimum rehabilitation of the employee. The right of the employee to select his attending physician should be maintained. The attending physician may be a member of the occupational health staff or any physician in the community willing and qualified to perform the essential services.

(b) Diagnosis and therapy in case of non-occupational injury or illness is *not* a responsibility of an occupational health program, with the limited exceptions noted below.

Emergency cases should be given the attention required to prevent loss of life or limb or to relieve suffering until the patient is placed under the care of a personal physician.

For minor disorders, first aid or palliative treatment may be given if the condition is one for which the individual would not reasonably be expected to seek the attention of a personal physician, or to enable the individual to complete his current work shift before consulting a personal physician.

In occupational health programs, requests for treatment of repetitive personal disorders should be discouraged, and such individuals should be referred to their personal physicians.

(c) The best interests of a patient are served by cooperation and communication between attending physicians and physicians in charge of occupational health programs. In this way, prompt restoration of employees to suitable employment can be assured.

5. Health and safety education.—A high standard of occupational health cannot be achieved without familiarity with, and the observance of, fundamental health rules. The development of an understanding of these rules and the promotion of their observance is an essential task in which an occupational health staff can render very valuable assistance.

An occupational health program should promote the education of employees in matters of personal hygiene and health and encourage the use of safeguards provided to protect against any hazards to health which may be inherent in their jobs. The most favorable opportunities for carrying on health education and counseling will be afforded during visits to health facilities and through periodic inspections of the employee's place of work.

Health and safety education involves the cooperative efforts of health, safety, and operating personnel. Such education should include not only the encouragement of habits of cleanliness and orderliness but also instruction, in collaboration with the employee's immediate supervisor, in safe work practices, in the use and maintenance of available personal protective clothing and equipment.

Experience has shown that health education is unlikely to be successful unless the employer demonstrates his sincere and continuing interest in the health of his employees. This entails participation by health personnel in health and safety meetings. Likewise, employees should be encouraged to participate in the planning and conduct of health education activities and to make full and effective use of occupational health services and facilities available to them.

An occupational health program, to be effective and acceptable to the employee, must be staffed by objective and competent personnel who create an atmosphere of warm, sincere, and positive personal helpfulness.

PERSONNEL

All phases of an occupational health program should be under medical supervision. This requires the appointment of a medical director, full-time or part-time, who is a qualified doctor of medicine. Training and/or experience in occupational medicine is desirable. The medical director should have a responsible role in the development and interpretation of medical policy. He

should administer the health program and be directly responsible to a designated official at the policy-making level of management. Additional physicians, as consultants or associates, may be required for an effective program. The duties of these physicians should be clearly defined by the medical director.

Qualified auxiliary personnel, selected and directed by the physician in charge, are essential to the proper functioning of an occupational health program. According to program needs, these may include nurses, industrial hygienists, first-aid attendants, and laboratory and clerical personnel.

A nurse should be a graduate of an accredited school of nursing, registered and legally qualified to practice nursing where employed. Training and/or experience in occupational health is desirable. She should assist the physician in the supervision of the health of employees while at work and in their health education. Her professional duties and nursing procedures should be clearly defined in writing by the physician to whom she is responsible.

One or more qualified first-aid attendants, known to all employees, should always be available during working hours. They should receive periodic refresher instruction and be provided with specific written instructions by the physician in charge.

FACILITIES

The facilities of an occupational health program may be available at the place of employment or in the community. When provided on the employment premises, facilities should:

1. Be located in a quiet area, readily accessible to employees;
2. Be sufficiently spacious, well lighted, ventilated and heated;
3. Include waiting, consultation, examining and treatment rooms, and toilet facilities, to insure adequate privacy and comfort; and
4. Have appropriate medical and laboratory equipment.

It may also be desirable to provide a rest or recovery room, dressing rooms and facilities for laboratory and radiological examinations.

CONCLUSION

Specific and detailed recommendations as to facilities, personnel and other aspects of individual occupational health programs obviously are beyond the scope of this statement. It is recommended that the local medical society be consulted to assure that a given program is in agreement with the objectives of this statement and with established community practices.

II. SUMMARIES OF TWO STUDIES CONDUCTED BY THE COMMITTEE

The preceding statement on occupational health programs delineates the area in which occupational health programs should function so as to respect both the needs of employees and the responsibilities of the profession. The Committee on Industry Programs believes that all will benefit from the two studies made by the staff. These studies deal with non-occupational medical care programs and workmen's compensation as they were found to exist in 1955. The studies are based on a 7% return of questionnaires mailed to almost 3,000 members of the Industrial Medical Association.

Non-occupational medical care programs in industry include those in-plant medical services which are not limited to illness or disability directly connected with the occupational environment. Workmen's compensation (occupational disability programs) are meant to provide medical care for specific work-connected illness or disability. The studies have attempted to bring out into the open such discrepancies as may now be existent. The findings of the reports are facts—not interpretations of the facts. Where these findings contain criticism, it represents the opinions of the persons who supplied information to the study group rather than those of the committee itself.

NON-OCCUPATIONAL MEDICAL CARE PROGRAMS IN INDUSTRY

The survey of non-occupational health programs in industry (Part II, Appendix D) has attempted to probe more deeply than has been done before into the extent of services, the nature of the programs, and the medical and ethical relationships involved. The report deals with such characteristics of in-plant programs as the number of full-time and part-time medical directors, their method of payment, and administrative authority. Almost two-thirds of the medical directors reporting were on a full-time basis, slightly more than this number were on salary or contract, and more than half were responsible to the personnel department.

The study of 244 in-plant programs, embracing over 1,440,000 employees, presents a picture of preventive medicine objectives with a variety of diagnostic aids and examinations employed primarily for the early detection of illness. A revealing aspect of this survey, however, was the extent of therapy for non-occupational illness as well as the existence of comprehensive medical care programs not ordinarily identified with industry.

Of the 244 companies studied, almost 80% have preventive medicine programs (as defined in the survey report). Again, of the 244 companies, 86 provide partial medical care, i.e., care beyond first aid, and 24 more provide comprehensive care, including dependents in some cases, in company medical facilities. Thus, over 40% of the companies, employing almost one-half of the employees in the survey, were found to be covered by medical programs in which partial or comprehensive medical care is an integral part.

The survey also brings to light acute problems in the relationships between the in-plant medical staff and general practitioners, management, and employees.

The method of referral of employees to private practitioners appears to underscore the reason for friction with the family physician. Direct referral by the medical director is not uncommon, and in some instances the medical director serves in the dual capacity of both plant and personal physician. Also worth noting is the fact that less than half of the medical directors appeared to maintain direct professional relationships with the family physicians.

The failure of many plant physicians to maintain such relationships, added to the volume of personal medical

care often provided in and outside the plant, has resulted in sharp criticisms against the medical director by some members of the medical profession. The general practitioner, too, has been critical of occupational health programs which, he believes, exceed their proper scope. As a consequence, many plant physicians are accused by other members of the profession of intruding upon the private practice of medicine, of attempting to provide personal medical care for which they are not equipped, and of interfering in the patient-physician relationship by criticizing the family physician and the services he renders.

On the other hand, plant physicians have criticized the family physician for being unaware of the true scope, objectives, and functions of occupational health programs; for failing to maintain objectivity regarding the patient's physical capacity, as evidenced by the granting of indiscriminate requests for illness certification; and of being uninformed on the etiology and diagnosis of occupational disease and the treatment of occupational injury.

Concurrent problems are also in evidence in relationships between plant physicians and management and between employees and unions. The committee emphasizes the need for prompt resolution of these problems.

OCCUPATIONAL DISABILITY PROGRAMS

The report on occupational disability programs (Part II, Appendix D) covers 201 companies with 860,438 employees in 37 of the 54 workmen's compensation jurisdictions for the years 1954 or 1955. Slightly less than half of the reporting employers were self-insured; the remainder were insured by private carriers or state funds.

Primary problem areas were reported in the following order of frequency by plant physicians:

1. Administration and interpretation of the law by state agencies.
2. Divergence of professional opinion on degree of permanent partial disability impairment.
3. Difference of opinion between plant physician and attending physician on cause of disability and length of treatment.
4. Lack of statutory provision and facilities for rehabilitation.
5. Deterrent to on-the-job rehabilitation posed by supervisory personnel and union rules.
6. Liability of employer for aggravation of pre-existing conditions and for disability resulting from degenerative diseases.

Referring specifically to occupational disability programs, only 11% of the physicians approved to provide medical services were full-time or part-time; the remainder served on call. More than half of the employers providing information on this subject had approved less than six physicians; the most common number was three. However, more than half of the employers providing information on this subject actually provided services by more than five physicians; the most common range was from six to ten. Of the physicians actually providing services, 92% were on a fee-for-service basis, the remainder being salaried or under contract.

Slightly more than one-fourth of the reporting employers provided medical care for occupational disabilities both in medical departments and by outside physicians. Of the cases reported by these employers, 93% received medical care beyond first aid in medical departments; 7% were handled by outside physicians. Reports on care provided either in medical departments or by outside physicians only were submitted by 12% of the employers.

Data on medical costs were extremely limited. Only 10% of the employers reported on medical department and outside service expenditures. None supplied a breakdown between physicians' fees and other expenses such as hospitalization and nursing. The fact that the average cost per case in medical departments was $4, as opposed to $68 for outside care, can be attributed in part to referral of serious and long-term cases to outside physicians.

Of the 46 companies reporting on administrative responsibility for workmen's compensation cases, about half assign it to the medical department and the remainder to industrial relations departments, insurance carriers, state agencies, or a combination of one or more of these.

The extent of rehabilitation practices may be gauged by the fact that only 30 cases were reported as referred to public or private agencies for vocational training and only 124 for physical rehabilitation.

Although the data compiled can hardly be considered a definitive study, they tend to support statements regarding major issues in compensation which were presented in the Commission's *First Progress Report*. These issues are (1) choice of physician, (2) supervision of medical treatment, (3) supervision of medical costs, (4) medical testimony, and (5) rehabilitation.

At the 1955 Clinical Session, the House of Delegates adopted the report on "Medical Relations in Workmen's Compensation" which had been prepared by the Council on Industrial Health. Since the adoption of this report significant progress in resolving the issues and problem areas noted above has been made. Its continued implementation will do much toward achieving the basic goals of workmen's compensation. In view of the importance which the Commission attaches to it, it is reproduced in its entirety as the next chapter of the report of this committee.

III. STATEMENT ON MEDICAL RELATIONS IN WORKMEN'S COMPENSATION[36]

THE MEDICAL PROFESSION'S INTEREST IN WORKMEN'S COMPENSATION

The workmen's compensation program in the United States was adopted primarily to meet certain needs of employees or their survivors resulting from disability or death of an employee arising out of and in the course of employment. In general, the program sought to remedy inadequacies stemming from common law and employers' liability statutes by providing laws based upon the principle of insured liability without regard to fault on the part of either employee or employer. Of primary concern was the provision of cash payments to replace a portion of wages lost by disabled employees. Little or no consideration was given to the provision of medical care for occupational disabilities. Under the federal, state, and territorial laws enacted between 1911 and 1948, the major emphasis of the various systems and their administration has continued to be on monetary satisfaction of liability, with insufficient attention given to the rehabilitation of the occupationally disabled.

Substantial progress has been made in the extension of medical care, the application of improved clinical techniques and other aspects of the rehabilitation process, including vocational training and selective placement of the disabled in kinds of work suited to physical and emotional capacity. It is a matter of great and growing concern that a considerable gap exists between potential services to the occupationally disabled and what is actually available to them.

In any event, many physicians have been deterred from widespread and active participation in workmen's compensation affairs. They are largely unaware of the significance of medical and economic policies under these laws and the undesirable and often harmful effects of existing systems. Whatever the causes, this attitude has been short-sighted and unwise to the end that not only workmen's compensation laws but other similar laws in related fields of social security are and have been formulated largely without medical consultation or any clear identification of medicine's primary interest. The predominance which economic considerations have come to occupy in both the professional and administrative aspects of workmen's compensation is a natural consequence. These same considerations have led to a concentration of professional services and responsibility in a few and not always the best hands. The Council's studies and others call attention to the need for critical appraisal of medicine's past record of performance and its present opportunities for the implementation of new and creative concepts.

The Council on Industrial Health is convinced through its consideration of the findings in this report that physicians have a duty and responsibility, both as members of professional organizations and as citizens in an industrial society, to improve the lot of the occupationally disabled. The several recommendations contained herein are presented with that purpose in mind.

GOALS OF WORKMEN'S COMPENSATION

The basic goals of workmen's compensation today are:

1. Rehabilitation of the occupationally disabled.
2. Assured, prompt, and adequate indemnity for the occupationally disabled or their survivors.
3. Minimal cost to employers and society commensurate with the above provisions.

IMPLEMENTATION OF THESE GOALS

The essential elements in the implementation of these goals from the medical point of view are described in the following sections of this report. Actually, sus-

36. *"Medical Relations in Workmen's Compensation: A Guide for the Evaluation and Implementation of a Progressive Program by the Medical Profession" (Report of Council on Industrial Health), J.A.M.A. 159:907-909 (Oct. 29) 1955.*

tained cooperative effort by all individuals and groups concerned with the welfare of the occupationally disabled are essential to success.

REHABILITATION OF THE OCCUPATIONALLY DISABLED

Rehabilitation implies the effective use of all disciplines and skills dedicated to the conquest of disability. Aside from great benefit to the disabled, their families and to society, current experience has amply demonstrated that the provision of rehabilitation services results in substantial savings in both medical and indemnity costs, just as the development of medical care provisions has resulted in savings in indemnity payments.

The establishment of workable rehabilitation programs calls for specific statutory provision; planned and improved cooperation from the medical profession; and intelligent, forceful administrative supervision.

1. Statutory Provision.—Periodically, workmen's compensation legislation and rulings come up for review. To implement a proper rehabilitation program the medical profession should seek adoption of statutory provisions that recognize these points:

(a) Rehabilitation of the occupationally disabled is the intent and responsibility of the compensation system and the legal right of the employee.

(b) The disabled employee is entitled to all services, appliances and supplies required by the nature of his disability or the process of his recovery and that will promote his restoration to or his continuance in employment. Services include medical, surgical, dental, hospital, and nursing attendance and treatment, as well as the training necessary to rehabilitation. Appliances and supplies include medicines; medical, surgical and dental supplies; crutches; artificial members; and apparatus. Services, appliances, and supplies are to be paid for by the employer under the supervision of competent professionals responsible to the administrative agency.

(c) In the absence of stipulated agreements, professional fees should approximate those that would be charged the employee as a private patient for similar services.

(d) Disabled employees should have the right to accept physicians' services provided by employers, or to select another attending physician from a register of all other physicians in the community willing and qualified to perform the essential services.

(e) Vocational counseling, training, transitional employment, and placement services require prompt analysis of problems, efficient screening, and referral and follow-up techniques to assure proper training and results. Effective supervision of these services in public or private facilities requires prompt reporting of occupational disabilities to the administrative agency.

(f) When necessary administrative procedures for such a system of rehabilitation of the occupationally disabled do not exist, or when adequate facilities are not readily available, steps should be taken to provide them.

2. Planned Cooperation from the Medical Profession.—Successful operation of a workmen's compensation system depends increasingly upon the medical profession. Although the administrative agency has the ultimate responsibility by law, medical care is the core of the system and physicians play a major role.

Every year hundreds of thousands of the occupationally disabled depend upon physicians for care and guidance from the beginning of disability until they return to gainful employment and even beyond. Physicians are also responsible indirectly for the payment of a substantial portion of their patients' income during disability. Compensation payments amounting to many millions of dollars annually are based upon reports and, in disputed cases, upon testimony provided by physicians.

The medical profession in each workmen's compensation jurisdiction can best fulfill its responsibilities by providing a broadly representative committee to advise the administrative agency on medical policies and practices and to assist in the operation of the system in the following ways:

(a) The committee should prepare and submit at stated intervals to the administrative agency appropriate information for its use in establishing a register of physicians who are willing and competent to accept calls for services to the occupationally disabled. Regulations governing enrollment on the physician's register should be established by the administrative agency after consultation with the medical advisory committee.

(b) It should mediate, if possible, complaints that a physician has neglected or refused to furnish reasonably necessary reports in accordance with general orders of the administrative agency.

(c) It should mediate, if possible, complaints of unreasonable interference with matters properly within the discretion and control of the attending physician.

(d) It should mediate, if possible, differences that may arise relative to remuneration.

(e) Claims of violation of medical ethics should be reviewed and relevant facts referred to the appropriate agency.

(f) Complaints should be heard about the compe-

tency of those serving on the physicians' register and recommendations made to the administrative agency concerning the removal of names therefrom, if complaints are justified.

If the advisory committee is unable to function promptly, the administrative agency should take appropriate action within the powers vested in it by law.

The medical profession should join with the administrative agency in sponsoring educational programs for all concerned on clinical and administrative problems in the compensation system. Other joint activities should include the development of proper medical report forms, desirable legislation to improve the workmen's compensation system and its administration, and handbooks for physicians.

3. Role of Individual Physician.—The primary obligation of the individual physician is to see that his patient is restored as nearly as possible to the economic and personal effectiveness which he possessed before he was disabled. This requires not only competent and impartial medical care but also that the physician use or recommend the use of other technical skills and resources available, whether in the community or not.

Physicians who wish to receive calls for service to the occupationally disabled should be prepared to assume duties and obligations which are not encountered in private practice. The best interests of the disabled patient will be served in the following ways:

(a) Concise, accurate information and reports descriptive of the disability should be furnished promptly and to the same extent to the patient or his dependents, the employer, the workmen's compensation insurance carrier, and the administrative agency.

(b) Testimony should be given before the administrative agency upon reasonable notice. The physician's testimony must adhere to reasonable scientific deductions regarding the injury, disease, or possible sequelae to the end that every deserving claim receives just consideration.

(c) Consulation should be requested in case of serious illness, especially in doubtful or difficult conditions, and agreement given for consultation with mutually acceptable physicians when requested by one of the interested parties. Effective rehabilitation goes beyond accurate diagnosis and expert treatment. Although the attending physician should remain in charge, he must embrace the modern concept of teamwork in the rehabilitation process. Physicians should not only cooperate with each other but also collaborate with the whole team of paramedical workers to assure maximum rehabilitation.

(d) Determination should be made by scientific methods and upon the basis of objective measurable factors of the permanent anatomic or functional impairment of a specific member or of his patient as a whole as compared to normal. From the medical standpoint, permanent anatomic or functional impairments cannot vary because of geographic locations or circumstances under which they were incurred. Therefore, the physician should determine the percentage of permanent impairment without regard to age, sex, occupation, or real, presumed, or potential wage loss. The application of these and all other factors provided by law to the percentage of permanent impairment established by the physician is the responsibility of the administrative agency in determining the indemnity award. In general, physicians are no more qualified by experience or training to evaluate such factors than any other disinterested individual.

4. Administrative Supervision.—Rehabilitation of the occupationally disabled requires a competent administrative agency with full statutory authority and responsibility.

The administrative agency must have more than adjudication and appeals functions; it must have an affirmative duty to see that the intent of the law is carried out. It may delegate functions, but it cannot abdicate responsibility. Proper discharge of this trust requires adequate resources in terms of qualified, permanent, professional personnel and proper facilities.

Duties should include supervision of the rehabilitation process and indemnity payments for permanent disability during and following the maximum rehabilitation of the disabled employee.

To assist in the administration of the law, the agency should seek the advice and active cooperation of appropriate professional, private and public organizations.

The administrative agency should have a medical director, approved by the medical profession, and a qualified vocational counselor. As staff officers, they should be in charge of the administration of appropriate provisions related to the rehabilitation of the occupationally disabled and should participate in such policy-making deliberations of the agency. They should have the full support of their superiors and constantly strive to provide leadership and promote effective professional relations in their fields through the maintenance of approved professional standards and practices.

INDEMNITY

The physician's interest involves recognition that the amount and method of indemnification have a direct and important bearing on an effective rehabilitation regime. While over-generous indemnity can dull the

will for rehabilitation, inadequate indemnity requirements can destroy an employer's incentive to support rehabilitation by providing him with an easier or cheaper alternative. More important, inadequate indemnity can lower patient morale or force return to gainful employment in advance of clear-cut medical indications.

In view of these relationships, it is consistent for the medical profession to support methods of indemnification which contribute to, rather than obstruct, rehabilitation procedures. Certain factors merit consideration:

1. Inadequate cash indemnity encourages "lump-summing" of payments, which tends to interfere with rehabilitation motivations. The practice should, therefore, be limited to instances where dependable evidence supports the contention that such a payment would contribute to the over-all rehabilitation of the employee. Problems of paying for legal, medical and other services should not influence the determination of whether a lump sum should be allowed.
2. Workmen's compensation is not a relief program. It is the proper intent of the program that a disabled employee and his family should not suffer a serious reduction in normal living standards during the rehabilitation period. This requires that the benefit level be maintained at an adequate percentage of usual wage and include reasonable personal expenses incurred by the employee in the course of the rehabilitation process.
3. Effective rehabilitation can drastically reduce the number of permanently disabled employees, which now constitutes the heaviest burden on workmen's compensation systems. Physicians interested in a rehabilitation program acceptable to permanently disabled employees recognize that attempts to relate indemnity payments solely to loss of earnings is impractical and unscientific. While it is not the purpose of workmen's compensation to indemnify all individual consequences of a disability, such as pain, suffering, and humiliation, the employee's right to personal effectiveness is not confined to employment or a limited period of time. Personal motivation to maximum rehabilitation can be hindered by complete deprivation of indemnity for permanent anatomic or functional impairment, whether it be a member or an organ of the body. Therefore, indemnity for permanent disability should be related to the employee's permanent impairment of earning capacity—in effect the anatomic and functional handicap incurred in working for a given employer. Maximum rehabilitation should be encouraged, and to this end the award for permanent disability should be based upon the effect of such a handicap on the earning capacity of the average employee so as not to penalize a disabled employee for exercising individual initiative.
4. The administrative agency should have continuing jurisdiction of these cases and indemnity payments should be subject to review whenever evidence is clear that the original evaluation of permanent impairment of earning capacity was in error.
5. Various methods of compensating employees with pre-existing permanent impairments have been devised. Most commonly the impairments must involve loss of a member that, combined with a subsequent injury, results in permanent total disability. In these cases liability is apportioned generally between the employer at the time of subsequent injury and a state fund established for this purpose. In recent years increasing consideration has been given to cases where the pre-existing condition is an organic disease that, combined with a subsequent injury, results in increased or total permanent disability. While the medical complexities alone of this problem are apparent, intensive study is currently being given to the equitable resolution of the whole problem when:
   (a) Further decrease in earning capacity or death of these employees can be clearly established on the basis of responsible scientific knowledge to be causally related to their employment; and
   (b) Such causal relationship cannot be so established.

CONCLUSION

The Council on Industrial Health wishes to emphasize again the importance of participation by physicians, individually and collectively, in a critical appraisal of medicine's past performance and its present opportunities for the implementation of new and creative concepts in workmen's compensation.

IV. CONCLUSIONS

SPECIFIC CONCLUSIONS

A. In-plant Non-occupational Medical Care Programs in Industry

1. In-plant medical care and occupational health programs represent management's concern with, and awareness of, its responsibility to safeguard the employee's health, to reduce work absence, to reduce turnover, to educate the worker in accident prevention and personal hygiene, and to match the physical and mental abilities of the applicant with the physical and mental demands of the job.
2. Occupational health programs are more likely to be found in companies with larger employment, i.e., 2500 or more employees.
3. Such programs are found to exist less frequently in companies employing between 250-500 people, and are virtually non-existent in companies employing fewer than 100 employees.
4. These programs were begun in the latter part of the 19th century to provide first aid to employees in hazardous industries and those located in communities far removed from medical facilities and personnel.
5. Some programs, however, such as those in the mining, lumbering, and railroading industries were established to provide personal medical care to employees as well as to dependents, in some instances, through closed panels. Medical facilities were established and physicians employed to provide these direct medical services.
6. Objectives of in-plant programs today range from the provision of first aid, safety programs, and preplacement examinations to comprehensive medical care.
7. The provisions for, and interpretations of, ambulatory medical care in these programs varies from program to program. The extent of medication generally parallels the scope of medical services rendered.
8. The majority of medical directors report to the head of the personnel or industrial relations department or some other member of the company; only a small percentage report directly to top management.
9. Considering the fact that almost 80% of the programs studied claim to emphasize preventive medicine, the low percentage of certain examinations actually conducted appears to raise some questions as to whether the objectives of occupational health programs are being realized.
10. Many programs engage in counselling and health education activities.
11. It is apparent that, in most companies, in the event the employee has no personal physician and is seeking one, his choice is often limited by the recommendations of the company representative.
12. Response to the Commission's questionnaire indicates that less than half of the medical directors maintain a direct professional relationship with the family physician.
13. The existence of widespread friction and misunderstanding is evident between the plant physician and the private practitioner.
14. It is apparent that many medical directors are not familiar with, or attaining the objectives and fulfilling the goals of occupational health programs.
15. Areas of misinterpretation and misunderstanding with regard to the role of the plant physician in an occupational health program also exist among employees, labor, and management.
16. Some physicians in in-plant medical programs appear to be engaging in activities which might lead to interpretations of violations of the Principles of Medical Ethics.

17. Impetus should be given to any program which will extend the advantages and benefits of occupational health programs to a larger percentage of the employed population, particularly among smaller companies.

B. Occupational Disability (Workmen's Compensation) Programs

1. Workmen's compensation was adopted originally to remedy inadequacies stemming from common law and employers' liability statutes by providing laws based upon the principle of insured liability without regard to fault on the part of either employee or employer. The major emphasis was, and continues unfortunately today to be, on monetary satisfaction of liability, despite advances in professional skills, technical knowledge, and substantial alterations in political, social and economic concepts.
2. Today restoration of the occupationally disabled to gainful activity should be the intent and responsibility of the compensation program and the legal right of employees. The implementation of such a program requires active participation by the medical profession from the initiation of appropriate legislation through the day-by-day administration of the program.
3. Such a program requires specific statutory provision insuring:
   (a) The full and effective use of all disciplines and skills dedicated to the conquest of disability under the supervision of a physician freely selected by the employee;
   (b) A competent administrative agency with full statutory authority and responsibility;
   (c) An advisory committee, composed of representative physicians, on the development and implementation of medical policies and practices by the administrative agency and to assist in the interpretation of these policies and practices to the medical profession; and
   (d) Recognition that the amount and method of indemnification has a direct and important bearing on effective medical and vocational rehabilitation of the occupationally disabled.

GENERAL CONCLUSIONS

The committee considers that it has obtained information on medical programs in industry to contribute to the integrated report of the Commission.

Nature and Methods of Operation.

Information obtained by the committee adequately describes the nature and methods of operation of medical programs in industry through which persons receive the services of physicians. This information is based upon the two survey reports which are contained in Part II of the final report and the data published in the Commission's *First Progress Report*.

Quality and Quantity of Medical Care Provided.

With respect to the effect of these plans on the quality and quantity of medical care provided in:

a) *Non-occupational medical care programs in industry*—the committee did not attempt at this time to measure the quality of medical care rendered through most of the above programs. It is the committee's opinion, however, that the quality of medical care provided by such programs in order to fulfill their responsibilities as occupational health programs is sometimes, though not always, superior to that which is, and has been, available to employees through physicians in the community. Furthermore, it is apparent from the survey which the Commission conducted that some programs are deficient in achieving the scope of medical services as outlined in the *Scope, Objectives, and Functions of Occupational Health Programs*, and are, consequently, not rendering the quality of medical care which such programs should possess. It is aware, also, that another committee of the Commission has included in its study a number of such programs which provide extended medical care. Such information will be considered by the Commission as a whole. It is evident that the very nature of such programs, regardless of their scope, do increase, the quantity of medical care and health supervision that would otherwise be obtained by the employee.

b) *Occupational disability programs*—the quality of medical care is affected by factors in the selection of the physician, the medical provisions of the law, administrative policies, and the monetary and economic considerations involving both employers and employees. Deficiencies in the quality and quantity of medical care in workmen's compensation today are not infrequent and are often attributable to third party interference with the traditional patient-physician relationship and the litigious atmosphere surrounding even the most minor injuries.

Legal and Ethical Status of Arrangements.

With respect to the legal and ethical status of arrangements used by occupational health programs, the committee observes that such programs owe their development, in large measure, to state laws governing work environment and workmen's compensation. The ethical status of arrangements in occupational health programs, both in-plant and workmen's compensation, has frequently been questioned. Such questions arise from lack of understanding and participation by the medical profession generally in the historical development of the proper administration of these programs. This lack of understanding and participation is due largely to the

fact that a very limited number of physicians are regularly engaged to provide medical and surgical services and many of them fail to develop proper professional relationships with the family physician.

Furthermore, it appears likely that, in certain occupational health and disability programs, the presence of third parties:

a. May affect the traditional patient-physician relationship when, for example,
   (1) The right of physician selection is vested in, or influenced by, the third party;
   (2) In-plant health programs exceed their scope, objectives, and functions by providing extensive personal medical care;
b. May introduce elements which affect their scope, and quantity of medical care when, for example,
   (1) The medical provisions limit the quantity of medical care available to injured employees in duration and/or dollar amount;
   (2) In-plant physicians unnecessarily interfere in, or raise doubts in the patient's mind about, treatment provided by personal physicians, and
c. May occasionally raise questions of violations of the Principles of Medical Ethics when, for example,
   (1) Patients are transferred by the third party from one physician to another, and
   (2) Medical information developed by the plant physician is improperly disclosed; that is, to management, personnel officers, supervisors, or foremen, without the consent of the patient.

As previously indicated, however, the newly adopted statement on *Scope, Objectives, and Functions of Occupational Health Programs* should be an aid in correcting existing deficiencies. The medical profession's implementation of the report on *Medical Relations in Workmen's Compensation* should similarly aid in achieving optimum goals and improved relations for all concerned.

student health services

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INTRODUCTION

Among the areas of study considered by the Commission on Medical Care Plans, and listed in its *First Progress Report*, was that of the provision of medical care to students, and in some instances employees, in colleges and universities. This subject was assigned to the members of the Commission who comprised the Committee on Miscellaneous and Unclassified Plans.

After reviewing the literature in this field and the preliminary work done by the committee, the Commission stated in its first report that "it was its consensus that, although these plans fall within the scope of the Commission's study and merit consideration, the other indicated areas of study are of more immediate interest and of continuing concern. Further activity in this area may be indicated after sufficient progress has been made in the study of other types of plans."

In the course of carrying out its other study and field work, the committee members, individually and collectively, interviewed persons who were either actively engaged in certain student health service activities or familiar with their operations. In addition, they familiarized themselves with the current problems and issues concerning these medical services.

The volume of work entailed in its other activities, however, did not permit the committee sufficient time to pay personal visits to what might be considered a cross-section of student health service plans. Moreover, as the committee studied miscellaneous and unclassified plans, and as it acquainted itself with the work of the other committees of the Commission, it began to recognize that certain of the problems involved in student health services paralleled those of the miscellaneous and unclassified plans and of occupational health programs in industry. The committee concluded that its contribution could best be made by referring the reader to the findings and results of several reports and studies of other groups or individuals, both within and outside the American Medical Association.

To be noted is the fact that on several occasions comments on these programs from various medical societies were elicited during the course of the committee field trips. The impressions received were that student health services were generally accepted by physicians in the community as "stop-gap" procedures to provide medical care during the students' period of dependency upon their parents. Through them the student can be taught, it was felt, an appreciation of the importance of securing medical care for himself and his family upon graduation. Certain reservations were expressed, however, by some physicians who questioned the scope of services of some of the programs in existence and the fact that closed-panel practice might possibly influence students to seek similar arrangements upon graduation. In addition, some questions were raised as to whether faculty members and other employees of the institution should be covered by such programs.

I. HISTORICAL BACKGROUND

President Stearns of Amherst College was probably the first college administrator to recommend a student health program. As early as 1856, he had called upon his board of trustees to establish a program to preserve the health of students. Under the guidance of Edward Hitchcock, M.D., this program became the model for the development of similar practices and procedures in this country.

An early development in college health services was the medical examination of students. College administrators were interested in such examinations both because the students benefited and because the college was afforded protection against the admission of students with serious physical defects or communicable diseases.

Meanwhile, with the development of public-health methods, colleges became interested in the improvement of campus sanitary conditions and in health protection of the student group, including provisions to handle communicable diseases. Health education ("hygiene instruction") was a later development to encourage students to utilize the services provided.

By 1927, as described by T. A. Storey, the program had come to include the following divisions: hygiene teaching ("informational hygiene"), medical service ("student health service"), physical activities ("applied hygiene"), and health regulation and supervision of the college ("administrative hygiene").[37] In 1930, the then relatively young American Student Health Association, since renamed the American College Health Association, passed a resolution at its annual meeting calling for the operation of a college program which would include "instruction in and development of physical and mental health, the supervision of the care of individual student health and illness, the sanitation of student environment, and the study of health problems."

The evolution of student health services and the problems of medical care and medical ethics involved attracted the attention of the American Medical Association. In 1936, Roscoe G. Leland, M.D., Director of the Bureau of Medical Economics, brought together a number of articles from *The Journal of the American Medical Association* and from other medical journals. This collection and other studies were published as a bulletin in 1936.[38] The *Second Survey of University and College Health Services* appeared in 1952.[39]

Since that time, there has been gradual evolution of college health services, with the American College Health Association playing a leading role in a series of national conferences on college health to stimulate development of these programs.

37. *T. A. Storey, Status of Hygiene Programs in Institutions of Higher Education in the United States (Stanford University Press, 1927), p. 23.*

38. *University and College Health Services (Chicago: American Medical Association, 1936).*

39. *Frank G. Dickinson and Everett L. Welker, Second Survey of University and College Health Services, 1949-1950 (Chicago: American Medical Association, Bureau of Medical Economic Research, 1952).*

II. RATIONALE AND OBJECTIVES OF THESE PROGRAMS

In an early report published by the American Council on Education, *The Health of College Students*, Harold S. Diehl, M.D., and Charles E. Shepard, M.D., suggested the following rationale for college health programs [40]:

There are two general classes of health problems affecting college students: (1) those resulting from deficient health care and education in the earlier years of life, and (2) those associated with the college environment itself. The health of the individual entering college reflects the health interest and information of his parents, the opportunities for health protection and teaching afforded in the lower schools, and the facilities for promotion of health in the community where he spent his earlier years. Lack of health care and education in these younger years is evidenced by the physical defects, emotional and social maladjustments, and health ignorance which individuals bring to college.

College life presents its own particular health problems. The student in college must find methods of overcoming or of compensating for educational and medical shortcomings in childhood, and must also face health situations different from those previously experienced. He must learn what to do in event of acute illness when away from parent or family physician, where to seek competent medical care, and how to discriminate in matters of diet, activity, rest, and other principles of healthful living. He must find sound sources of medical information and must learn how to use this counsel in the solution of his own physical and emotional problems. As a member of a special group in which society has invested heavily, he should become a leader of thought in those concepts by which family and community health may be preserved.

According to the Report of the Third National Conference on Health in Colleges,[41] the over-all objectives of such a program are as follows:

1. To create a healthful environment and atmosphere in which students may develop physically, mentally, and socially and in which they may learn to live more happily as health-minded citizens in their personal lives, in their homes, in their communities and as members of a world society.

2. To provide means whereby administrators, faculty and all other college employees may be enabled to work together cooperatively for the total health of all.

3. To facilitate the practical application of health knowledge to daily living in the medical clinic, the classroom, on the campus, and in the community.

4. To safeguard the health of students, faculty, and nonteaching personnel through the prevention of communicable diseases.

5. To develop well-adjusted students and graduates who possess information, attitudes, habits, skills, and ideals favorable to efficient and healthful lives for themselves, their families, and their communities.

6. To assist college students to assume responsibility for their own health, so that they will know when they are in good physical and emotional condition, will recognize deviations from the normal, and will know when and how to seek expert assistance to meet their health needs.

7. To provide scientific knowledge through a well-integrated plan of health education, so that students will be able to evaluate pseudoscientific reports and advertising campaigns regarding health and disease nostrums.

8. To prevent loss of study time and promote the development of efficiency in pursuing college work by insuring maximal personal and community health.

9. To assist students who are moving from their homes to unfamiliar college environment to find competent and adequate medical care when they become ill. It is hoped that such experience will inculcate habits and attitudes which will help students later in the solution of their medical problems in adult community life.

10. To develop a working arrangement among members of the college community to promote a single policy of healthful living on the campus.

40. Harold Diehl and Charles Shepard, The Health of College Students: A Report to the American Youth Commission (Washington, D.C.: American Council on Education, 1939), pp. 6-7

41. A Health Program for Colleges (New York: National Tuberculosis Association, 1948), pp. 17-18.

At the next such conference, held in New York in May, 1954, the purposes of the college health service were defined as follows[42]:

The college health service has a major interest in the development of an adequate college health program. As one participant stated: 'The term *hub* expresses well the way in which the health service fits into the whole health program. In small institutions the health service may be all of the program.' In the larger schools, the health service may be only one of the several parts of the college health program.

According to the report of the conference, the minimum satisfactory college total health program should include (1) health service; (2) physical education and recreation (health aspects, only), both general and, for those with defects, corrective; (3) health education, both fomal and informal; and (4) medical aspects of disaster preparedness.

In this program, the health service was visualized by the conference participants as a combined agency primarily responsible for: (1) personal health, including (a) evaluation by physical examination, (b) protection by medical care and immunization, and (c) promotion by correction of remediable physical defects, health counseling, and education; (2) public health, including (a) disease prevention and control and (b) participation in, or responsibility for, promoting a healthful environment; and (3) participation in and promotion of health education, medical aspects of physical education, recreation, and sports, and physician-patient and nurse-student counseling.

The extent to which these services are actually provided was described as depending upon the availability of the services in the community[43]:

In a college where the majority of the students live at home, the necessity for providing actual medical care may be slight; in a large school in a small city or in a residential school the demands may be much greater.

In any event, it is a responsibility of the health service to see that every effort is made to establish at least the safe minimum of health protection for the students. It has been pointed out that public health regulations are geared to the minimum standard of health protection; a college, to fulfill its education mission, needs to establish standards that can be used as a measure for optimum protection and health education.

42. *Proceedings of the Fourth National Conference on Health in Colleges (New York: American College Health Association, 1955), pp. 35-36.*

43. *Ibid.*

III. SCOPE OF THE PROGRAMS AND METHODS OF FINANCING

The student health service is considered by many persons to be a temporary provision to furnish the student needed care while he is away from home and the college stands, in effect, *in loco parentis*.

There is a great difference of opinion among physicians directing college health services as to the levels of care that should be provided. Some feel that the college's responsibility involves only essential immediate-emergency care. Others believe that comprehensive medical care is the proper answer. All agree that local conditions, including the type of institution and the number of students living at home and boarding, apparently influence what the college provides.

One committee of the Fourth National Conference on College Health listed the following levels of medical care at present being provided in colleges and universities[44]:

1. A nurse who can operate a first aid station for injuries and can refer ill students to physicians in the local area.
2. A physician available on a part time basis to handle entrance physical examinations of the students.
3. A physician who has office hours throughout the year during which students can, upon request, be given minor treatment and advice, and can be referred to local physicians for more complete attention.
4. The services described in (3) with infirmary or hospital care provided.
5. More complete professional services including the services of certain specialists.
6. A still more complete and comprehensive service including preventive medicine and mental hygiene.
7. Comprehensive medical care for all possibilities during the period of the school term so long as the student is near the college.
8. The expansion of comprehensive medical care to include dental services, eye examinations, and all services compatible with student life.

44. *Op. cit.*

The same committee also reported:

Insurance and pre-payment plans were especially suited to cover the professional services for the student and his hospitalization. The other necessary and desirable services are relatively less expensive, relatively more predictable, and more easily controlled. Ordinarily, it is not wise to finance these costs by insurance.

The following possible pre-payment plans were listed: (1) purchase of commercial insurance; (2) self-insurance; (3) Blue Cross or Blue Shield Plans or those specifically tailored for college needs by the various states' physicians services; and (4) contracts for service usually associated with group practice and capitation of the above.

College health services are commonly financed through (1) a health fee paid by each student, plus minor charges for hospital services; (2) budgetary appropriations from general funds; (3) health fees supplemented by funds from the general budget or from other sources; or (4) insurance carried by the school or by the individual.

According to the conference's report[45]:

No college should attempt to operate a health service unless it can provide a quality of medical service equal to or better than that available in the area. As an educational device in furthering and in demonstrating good medical care, the college health service should be satisfied only with better than average service. The bulk of medical care in the college health service can be provided by the general practitioner with specialists available for the unusual cases.

The college health service may overlap or even duplicate services offered by local medical facilities, such as hospitals, public health department and voluntary agencies. It should not attempt to compete with or supersede the functions of any existing outside agency unless it can be reasonably certain that such a course is to the decided advantage of the majority of its students.

45. *Op. cit.*

IV. SURVEY FINDINGS

One of the most recent and comprehensive evaluations of student health services in the United States is contained in the report of an American College Health Association survey.[46] The 1,157 colleges and universities surveyed represent 61% of all colleges in the country. Of the 1,157 colleges, 200 "do not assume the responsibility for health of students in any way. Certain specific services are found at a majority of the 957 colleges with a health program, while other specific services and procedures are found only sporadically throughout the country." The following paragraphs summarize their findings:

General administration.—There is no uniform or standard health program for college students.

The widest differences in student health services are related to the size of enrollment at a college. The data show that the larger the college, the greater is the possibility that a health service exists and the more comprehensive are the services, facilities, and medical staffs available.

Preventive procedures and detection of diseases.—A definite majority of the colleges with a health service keep medical records for enrolled students.

Among the most common procedures for protecting campus health is the requirement of a physical examination for entering students. About half of the colleges with a health service require entering students to have vaccinations for smallpox, chest x-rays, or routine vision examinations. About the same proportion of colleges require periodic physical examinations for enrolled students. Immunizations for tetanus, typhoid, or diptheria are required by not more than 15%.

Health education is taught at most colleges, and credit for courses is granted by a high percentage. Three-fourths of the colleges with a health service also provide medical care for athletes.

Clinical care.—Clinical services are maintained by 80% of the colleges, but these are likely to be for minor rather than major illness. Most clinical services are extended to "all" students and are used by the majority of students at most colleges. They are likely to be on a 24-hour basis, and they provide house-call service more often than not.

Clinical programs usually include treatment services for minor cuts, colds, gastrointestinal upsets, mild anxiety reactions, communicable diseases, and allergies. Drugs are available in about eight out of ten college clinics.

College infirmaries are maintained by more than three-fourths of the colleges with a clinical program. Such infirmaries are typically for minor illness only, and the average bed capacity is 13 per 1,000 enrollment.

Clinical services are extended to faculty and other employees at about half the colleges; and to wives and children of students at about 10%. Treatment is provided for acute febrile illness, fractures, and severe concussions, by nearly half of the clinical services.

Important services found infrequently include eye refraction examinations, comprehensive speech and hearing examinations, and psychiatric examinations. Clinical care for acute abdominal disorders or severe emotional difficulties is provided by less than one-fourth of the colleges with a clinical program. Relatively small numbers of health services make facilities available for dental work, electrocardiograms, and electro-encephalograms. Patients are admitted for surgery by 11% of the college infirmaries.

Personnel.—Eight out of ten health services have a staff physician—typically one part-time physician only. Full-time nurses are employed by seven out of ten health services. Full-time physicians are found at 21% of the health services. Various medical and non-medical specialists are employed by not more than one out of five. A minority hold regularly scheduled staff meetings.

Finances.—A majority of the health services have an annual budget of less than $10,000. Colleges are more likely to finance health services through general operating or tuition funds than by means of a special health fee. The median amount allocated from these funds for health purposes is $7.25 per student per school year. Special health fees have been established at 30% of the colleges with a health service. Total health budgets exceed $100,000 at 46 of the 1,157 colleges surveyed.

A survey of student health services by Frank G. Dickinson, Ph.D., and Everett L. Welker, Ph.D., for the years 1949 and 1950[47] contains information based on the replies of 462 colleges, which supplements the preceding data. Among their findings were the following:

Required health insurance for students by an outside carrier was rarely reported. Only 4% of the colleges required this coverage, while 11% offered it as optional. Student health services are usually financed by a special fee (48%) or by a fee included in tuition or student fees (29%).

Medical treatment for ambulatory student patients involving more than "emergency care only" was reported by 88% of the colleges. This service is most commonly provided by the health service staff (physician and nurse) and only rarely by outside physicians.

46. Norman Moore and John Summerskill, Health Services in American Colleges and Universities, 1953 (Ithaca, N.Y.: Cornell University Press, 1953).

47. Dickinson and Welker, op. cit.

Some check on the health of new students is made by almost all colleges having college health services; 70 percent require a routine health examination and 25 percent accept a family physician's report instead. Follow up of defects thus discovered was reported by 63 percent of the colleges.

A recent report which summarizes the discussions of a workshop devoted to employee and student health services[48] reveals some interesting information concerning 15 university medical centers. The participants defined a health service "as an organization within an institution devoted to some degree of preventive medical care, health promotion, counseling, direct medical care, and research, which is practiced on a selective group of participants, and maintains high standards, with implications of good public relations and employee fringe benefits." Among the findings of the report were the following:

Students in various specialties and disciplines, members of the house staff, employees of various schools, members of the faculties, employees of research institutes or of special facilities considered part of the medical center, and, in some instances, volunteers rendering periodic service and dependents of students and faculty may participate in the program. (This listing does not imply universal inclusion, but rather various combinations).

In some medical centers, the health service is identified with industrial health or occupational medicine. Thus, "In those areas where the wage structure is minimally scaled, greater latitude will exist in the inclusion of employees in the Service. When a Center adopts more of the administrative methods of industry, the Health Service will offer a program to the employees as a fringe benefit—in keeping with contemporary personnel relations —and the figure of an industrial health unit is given substance."

Students seeking admission to a professional or graduate schools are required to submit a report of a physical examination. This is accomplished most frequently by the physician of the applicant's choice, or by the undergraduate campus health service, or occasionally by the health service of the medical center.

Practice with regard to periodic physical examinations varied; some institutions examine students annually, using members of the resident staff who are paid on an hourly basis. Other institutions conduct a repeat examination in the fourth year when such reports are required as part of the interneship application. The workshop participants questioned the completeness with which this examination was made. Where the student does not receive his medical care from the health service, his own physician makes the examination.

Fees to students vary from $4 to $30 per year for medical students as well as student nurses.

There is a wide variation in medical services offered. Emergency care is provided by all health services, "but policies differ as to the extent of care for elective or static conditions." Medical students tend to utilize the health service more frequently in their first year than later.

Policies vary as to the duties of the health service physician; sometimes he is in charge of the student's illness during hospitalization; sometimes the attending physician, a full-time staff member of the university hospital, renders the medical care and submits reports to the health service.

Medications are usually supplied to the student through the university hospital at cost, or they may be included as part of the fee. The exceptions may be expensive vitamin or cosmetic preparations.

Prepayment for hospitalization represents one of the areas of concern to the health services. Some schools utilize Blue Cross and Blue Shield on a voluntary basis; if the schools were to provide hospitalization, fees would have to be increased. "In a few Medical Centers it was the experience that the Blue Cross had collected in premiums as much as three times the hospitalization costs among the insured student groups. As the Blue Cross Plan adheres to a 'standard' experience pattern, the hospitalization needs of a student group, in a Medical Center with a Health Service, are viewed out of proportion to the usage figures. Other underwriters can provide a combined policy of hospitalization and surgical fee indemnification, at less than Blue Cross charges alone." The author states, further, that "the thinking is turning to a fuller outside insurance underwriting of the student groups."

Immunization programs on a voluntary basis are considered "a primary function" of the health service. Such programs are "not compulsory, but the 'volunteering' is essentially of military styling."

The health service is regarded as a means of providing an opportunity for the student to "begin to feel an awareness of his own health behavior, and of the interrelationships between stress and physical response."

One center provides coverage for dependents of students and faculty. This school has 2,500 employees, 300 medical students, 500 nurses, and 1,000 faculty members. By the fourth year, half of the students were married, as were 60% of the house staff. The service is extended to the families of full-time faculty members. House calls are made within a five block radius of the hospital; the services of a well-baby clinic are available, and discounts are offered on certain items. "This is provided without charge, but it is felt that, because of a certain amount of dissatisfaction, there should be some subsidization of this medical care by the students."

There is some divided opinion as to whether an employee of the medical center should receive free medical attention, since academic and non-academic personnel have different rights and privileges.

The health service provides medical care for occupational illness and injury, and periodic examinations are given to employees.

Several health services have created advisory committees representing various agencies in the medical center whose personnel are served by the health services. The committees may be composed of the deans of various schools, the business administrator, certain hospital department heads, and representatives of employee and student groups.

The director of the health service reports to the vice-president in charge of medical affairs, in the case of a single campus, or to the president, where smaller institutions are involved. The medical director may be responsible to the head of the center, to the director of the university hospital, or to the head of the department of preventive medicine.

Some services are staffed by a part-time physician. Residents, who may work on an hourly basis or for experience only, assist in providing medical care. In some cases, fourth-year medical students work nights and week ends, with this type of duty classified as an externship.

The participants in the workshop felt that "clinical records could be made more intelligent and meaningful." The completeness and accuracy of records apparently varied according to the type of service in effect and the motivations for maintaining them.

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48. Jean Spencer Felton, "Employee and Student Health Services at University Medical Centers: A Preliminary Report of the University of Oklahoma Medical Center Workshop," Industrial Medicine and Surgery, vol. 26 no. 2 (Feb.) 1957.

V. CONCLUSIONS

The committee has limited the scope of its survey of Student Health Service plans to a compilation of pertinent literature and representative views on this subject. Attention is called to the fact that the Bureau of Health Education of the American Medical Association has studied, and is studying, various aspects of these programs. The resources of this Bureau and the benefits of its experiences and opinions were utilized in the consideration of this area of health care.

Large numbers of students are dependent upon colleges for their health care because in many cases they reside at a distance from their homes and, in other cases, the colleges are located in small communities with limited medical facilities. Medical care benefits, as well as housing facilities, educational grants and other advantages are among the influences which affect the student's opinion during his university training. The characteristics of the program to which the student is exposed, the quality of medical services, and the satisfaction derived by the student will have a decided influence on his attitude toward medical care when he assumes his position in his community after graduation.

The great variation in the characteristics, methods of operation, and scope of this large group of plans makes generalization and over-all conclusions very difficult. Without intending to deprecate the large amount of previous investigation and analysis in this field, it is apparent that much further consideration and study is required if definitive answers to the Commission's questions are to be formulated.

1. QUALITY AND QUANTITY OF MEDICAL CARE PROVIDED

After inquiring into the nature and methods of operation of these plans, as previously described, the committee believes that the quantity of medical care has been increased by their existence. Since the quality of medical care is intimately affected by the wide variance in the characteristics of these many individual programs, the committee has found it difficult to arrive at an over-all assessment and conclusion regarding the quality of medical care in these plans.

2. LEGAL AND ETHICAL STATUS OF ARRANGEMENTS

With respect to the effect of these third party mechanisms on the patient-physician relationship and resultant medical care, the committee wishes to point out that the student-physician relationship under a student health service plan is transient and temporary. The personal physician is not entirely or permanently replaced.

The nature of the committee's study of student health services has not provided adequate information to determine whether there is a tendency on the part of physicians participating in these programs to violate the Principles of Medical Ethics.

Although some of these mechanisms utilize closed panels and involve compulsory participation by the student, the peculiar circumstances surrounding such care have resulted in the acceptance of many of these plans by local medical societies. Likewise, many programs containing similar characteristics in the Miscellaneous and Unclassified group and in industry have encountered no serious criticism.

Such plans, in and of themselves, do not appear to be encouraging the practice of medicine by educational organizations, whether they be corporate or other forms. If, however, services were rendered to students by health service physicians for fees which were collected and used for the benefit of the educational institution then, in such cases, these plans would be encouraging the practice referred to above. It should be noted that these plans are largely departments of educational institutions and are not legal entities, per se.

The committee believes that the proper relationship between the medical profession and student health services should be one comprising study and participation; encouragement and understanding, and consultation and advice.

judicial council opinions and house of delegates policy statements

The Committee has traced the chronological development of several sections of the Principles of Medical Ethics and has reviewed certain actions of the House of Delegates and reports of the Judicial Council in relation to those sections (Part II, Appendix G).

When the Principles of Medical Ethics were first adopted by the Association in 1847 they contained a section which read:

> There is no profession, by the members of which eleemosynary services are more liberally dispensed than the medical, but justice requires that some limits should be placed to the performance of such good offices. Poverty, professional brotherhood, and certain of the public duties referred to in the first section of this chapter, should always be recognized as presenting valid claims for gratuitous services; but neither institutions endowed by the public or by rich individuals, societies for mutual benefit, for the insurance of lives or for analogous purposes, nor any profession or occupation, can be admitted to possess such privileges. Nor can it be justly expected of physicians to furnish certificates of inability to serve on juries, to perform militia duty, or to testify to the state of health of persons wishing to insure their lives, obtain pensions, or the like, without a pecuniary acknowledgment. But to individuals, in indigent circumstances, such professional services should always be cheerfully and freely accorded.

In 1912 the following statement was added to the Principles of Medical Ethics:

> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

It was at this time, probably, that a distinction between ethical and economic principles began to come into focus. From 1912-1913 on, many of the actions of the House of Delegates and the reports of the Judicial Council reflect continuing efforts to view ethical and economic concepts from proper perspective.

With the opening of the West, with the development of mining and logging camps, and the extension of railroads into the then remote areas came the problem of "contract practice" as the term is used and understood today. The Judicial Council report for 1913 contains the following statement:

> Surgeons and physicians are employed by these corporations partly as a matter of self protection that they may properly care for the accidents occurring in the transaction of their business and that they may be protected against unjust damage suits that are likely to occur . . . Besides this self defense of the company there is growing appreciation by large corporations that the better the health of their employees is protected, the better will be the results obtained in their work, and hence, while it may tend toward benevolent and socialistic ideas, it is really a question of economic efficiency.

At the same time, "lodge practice" was popular. The Judicial Council reported in 1913 that "medical attendance in the lodges and fraternal and benevolent associations is a part of the inducement for the joining of these associations." And in the same year the Judicial Council noted:

> It is useless to struggle with "whereas" and resolutions against these economic facts. It is time for the AMA and its constituent bodies to look these facts squarely in the face, to accept them and by instituting fair control to see that justice is given to the members of the profession and that an equal social justice is given to the poor whose necessity demands this sort of service . . .

In the 1920's complaints apparently became more numerous concerning the practice of medicine by corporations other than those mentioned in the previous paragraph. The reports of the Judicial Council seem to suggest that around this time some corporations or other lay groups, with altruistic intent, undertook to help the less financially fortunate by employing physicians to render medical care to the recipients of the corporation's charity. But, the Judicial Council pointed out in 1930:

> When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served.

In the ensuing years the problem of medical practice by lay groups appeared to become more acute. The Council reported in 1932:

> . . . in increasing numbers physicians are disposing of their professional attainments to lay organizations under terms which permit a direct profit from the sale or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interest of the patient.

Outstanding examples of these practices were said, by the Council, to include insurance companies administering workmen's compensation benefits where the salaries or fees paid to the physicians by the insurance company were so much below the legal fees on which the premium paid by the industry furnished a large direct profit to the insurance company; hospitals which forbade their staffs of physicians to charge fees for professional services to house cases, but were themselves collecting such fees and absorbing them in hospital income; universities which employed full-time hospital staffs and opened their doors to the general public charging such fees for the professional care of the patients as to net the university no small profit.

In 1934 the Principles were amended to proscribe as unethical the exploitation of the physician by lay groups. And, although the 1912 amendment to the Principles, above, had been called "contract practice," it was in 1934 that the Principles were amended to include a definition of contract practice, and a statement regarding the ethical nature of "contract practice." For the first time, mention was made in the Principles of "free choice of physician." (In 1949 the phrase was defined in a separate section of the Principles).

The Principles were further amended in 1934 by adding a statement to the effect that inasmuch as groups and clinics are composed of individual doctors, the individuals thus united must individually observe the Principles.

During the 1930's two further developments were noted; the increasing practice of medical specialties by hospitals through licensed employees, and the advent of prepaid medical and hospital care plans. In 1934 the House of Delegates adopted the *Ten Principles* for the guidance of medical societies in the formation and operation of such plans.

In all actions concerning prepaid medical care plans which have been reviewed by this Committee, the Association has emphasized that all physicians participating in such plans should observe all principles of medical ethics.

In regard to the practice of medicine by hospitals, the House of Delegates repeatedly declared that the medical specialties (radiology, pathology, anesthesiology and physiatry) are the practice of medicine. One resolution adopted in 1947 by the House of Delegates expressed the House's firm opposition to the encroachment by hospitals and other organizations on the private practice of medicine and stated that it was the policy of the House that all fees for medical services should be set by, and collected by or for, doctors of medicine rendering this service. It further stated that all policies and practices involving medical services be approved by the medical board or medical staff before being put in effect.

From the earliest edition of the Principles, the solicitation of patients was declared to be unethical. In 1949 the Principles were amended by adding a section relating to the relation of physicians to media of public information which differentiated solicitation of patients from the physician's civic responsibilities having the purpose of improving the health and well-being of both the individual and the community.

More recently, third party mechanisms have again become a concern and interest to the House of Delegates and the Association. During the past few years the *Twenty Principles* (1949); *Guides for Conduct of Physicians in Relationships with Institutions* (1951); *Report of the Joint Committee on Hospital-Physician Relations of the Boards of Trustees of the American Medical Association and American Hospital Association* (1953); *Medical Relations in Workmen's Compensation* (1955); *Guiding Principles for Evaluating Management and Union Health Centers* (1955)* and *Suggested Guides to Relationships between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund* (1957), were adopted by the House of Delegates.

In June, 1957 the House of Delegates adopted a revised version of the Principles of Medical Ethics which includes the statement that,

> a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

CONCLUSIONS

A review of the chronological development of the Principles of Medical Ethics relating to *Advertising, Groups and Clinics, and Compensation*, and actions of the House of Delegates and the Judicial Council concerning them is the basis for the following conclusions:

1. The federated, constituent medical associations comprising the American Medical Association speaking through the A.M.A. House of Delegates have always been mindful of medicine's obligations to the medically indigent;
2. They have consistently recognized the necessity of preserving the patient-physician relationship without interference from a third party;
3. They have repeatedly reiterated their belief that no direct profit should accrue to lay groups from the sale of the professional services rendered by physicians;
4. They have always held (and have recently reaffirmed in the 1957 Principles) that a physician may not in the best interests of his patient dispose of his services under terms or conditions which tend to interfere with or impair the full, free and complete exercise of his medical judgment or skill or tend to cause a deterioration of medical care;
5. They have maintained that the resolution of the misunderstanding arising out of the economic influences and ethical principles should be resolved locally.

Your Committee would repeat the statements of the Judicial Council made in various years to illustrate the philosophy which has guided the Association in judging various developments and which underlies the profession's approach to all problems in which the practice of medicine is involved:

> The Judicial Council believes that . . . these societies should use their influence and power not to condemn the physician who must take the contract by ostracizing him but to prevent underbidding for these contracts below what would give a fair reward for medical services rendered . . . (1913)

> It is hoped that the public and those who have been misled by the promises of certain new forms of medical care will finally realize that any plan which destroys professional control over the quality of medical service will only result in a low grade of service which in itself may have so many potentialities for danger to health and life as the illness from which the individual seeks relief. (1938)

Each case must be judged on its own merits after all the facts pertaining thereto are known. There are certain points, however,

*Rev. 1957; new title: *Guides for Evaluation of Management and Union Health Centers.*

which may be formulated which when present, one or more of them, definitely determine a contract to be unfair or unethical . . .

1—When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

2—When the compensation is so low as to make it impossible for competent service to be rendered.

3—When there is underbidding by physicians in order to secure the contract.

4—When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

5—When there is solicitation of patients directly or indirectly. (1927)†

†*Re-adopted by the House of Delegates, 1957 Clinical Session.*

The foregoing should lay to rest any assertions that the profession is insensitive to, and unaware of, new trends and developments in medical practice. Such developments as occur, however, must contain safeguards and conditions which will respect the rights of physicians and patients both to render and to receive medical care of the highest quality. Toward this end, the profession must continue to delineate those practices and conditions which would militate against the provision of good medical care and result in care of an inferior quality. The guides and statements which have been enunciated by the Association in response to local and national situations reflect the Association's continuing concern with the maintenance and perpetuation of an ethic which is dedicated to the public interest.

RECOMMENDATIONS

recommendations

MISCELLANEOUS AND UNCLASSIFIED PLANS

A. Those concerning activities of state and county medical societies.

1. County and state medical societies should engage in a continuing review and study of those types of medical care plans which are included in the Miscellaneous and Unclassified category. This study should include an appraisal of practices in the closed panel, direct service, type of medical care plans as well as similar practices existing in the occupational and non-occupational medical care fields.
2. County and state medical societies should maintain active liaison committees in the medical care plan field in study, advisory and mediation capacities.
3. County and state societies should consult competent legal counsel familiar with federal and state laws when controversial problems affecting medical care plans arise.
4. Medical societies should exert more effective efforts to eliminate unnecessary and excessive use and abuse of medical care plan benefits by a small minority of physicians.
5. State and county medical societies must be alert to legislative activities concerning medical care plans in order that the welfare of the public and the profession is served by sound legislation.
6. County and state medical societies should be responsive to any demonstrated needs in aiding in the establishment of mutually satisfactory mechanisms for the provision of good medical care to specific segments of the population requiring such service.
7. "Free choice of physician" is an important factor in the provision of good medical care. In order that the principle of "free choice of physician" be maintained and be fully implemented the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.

B. Those concerning activities of the A.M.A. and medical care plans in general.

1. Appropriate facilities of the A.M.A. should be utilized to conduct a continuing study of socio-economic problems and trends as they affect the development and operation of all medical care plans.

   Periodic surveys should be conducted in the medical care plan field to follow accurately changes and trends in various categories of medical care plans. Special attention should be given to the accumulation and use of health and welfare funds in the extension of these prepaid health plans in order to observe their impact on medical practice.
2. To permit valid comparisons, uniform criteria should be promulgated and applied to measure utilization of services in medical care plans.
3. Improvements in coverage should be one of the continuing goals of medical care plans.
4. In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, medical care plans should strive toward the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made.
5. Medical schools should be encouraged to devote more teaching time to problems in the socio-economic field of medical care.
6. Medical care plans should be encouraged to increase their efforts to provide health education and information concerning their plans to subscribers.
7. Medical policy and medical administration of medical care plans should be controlled by physicians.

Purely business functions may be handled by others who are employed for that purpose.

8. Governing boards of medical care plans should include physician representation.
9. There is no unanimity of opinion as to the scope of service included in "comprehensive medical care," and the use of the term is misleading. Medical care plans which claim to offer "prepaid comprehensive medical care" should clearly describe their exclusions and limitations.
10. Each individual should be made aware of the payment made by his employer for his medical care plan.
11. Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care.
12. Physicians should be encouraged to serve on advisory councils of medical care plans.
13. Plans should confer with local and/or state medical societies before embarking on new medical care programs. This will tend to prevent misunderstanding.
14. Increased efforts should be made by appropriate facilities of the A.M.A. to develop information and to discuss controversial problems with sponsors of the plans as well as state or local medical societies and when requested by the parties concerned to develop effective mechanisms for resolving disputes consistent with the policy of the House of Delegates and the autonomy of the constituent associations.
15. The A.M.A. and its constituent medical societies should increase their efforts to educate members as to the operation and function of medical care plans in order that the entire profession may be conversant with all the problems involved.
16. The principle of "free choice of physician" should be applied as universally as is practicable. Each plan member should have the widest possible choice of physician.
17. An appropriate committee from the A.M.A. should sponsor national and regional conferences with representatives of all parties concerned. Guides for the relationship between the medical profession and these third parties should be considered and developed based upon recognition of the interests and obligations of plan members, physicians, and third parties, as enumerated in Section IV on "Third Party Relationships in Miscellaneous and Unclassified Plans" in the Report of the Committee on Miscellaneous and Unclassified Plans. At such conferences, mechanisms and procedures should be agreed upon for resolving controversies which might exist between the medical profession and these third parties. These mechanisms and procedures should be acceptable to all third parties concerned and to the medical profession, and should be included in the guides, in so far as is possible.

    Such a course of action resulting from the Commission's study should be given wide publicity so that all persons and organizations may become well acquainted with, and correctly informed regarding, the policies, beliefs, and constructive efforts of the medical profession in the medical care plan field.

recommendations

MEDICAL SOCIETY APPROVED PLANS, INCLUDING BLUE SHIELD, AND PRIVATE INSURANCE PROGRAMS

Since health insurance is the means by which the health care costs of a great and growing percentage of the population is financed, its continued development and operation are significant to the profession of medicine. In varying degrees nearly all physicians are affected by health insurance in their daily practice.

The rapid and continued growth of health insurance justifies fully the foresight of the American Medical Association in creating the Council on Medical Service in 1943 to study on a continuing basis (among other matters) the broad aspects of these developments through the Committee on Prepayment Medical and Hospital Service.

In view of the foregoing, and because health insurance probably will assume an ever larger role in the financing of health care costs, it is recommended that:

1. Since the preservation of the American system of private practice of medicine may well depend on the success or failure of voluntary health insurance in financing health care costs, it is recommended that the activities within the American Medical Association in matters relating to health insurance be expanded as rapidly as possible.
2. Constituent associations and component societies be encouraged to create or expand their facilities for studying and dealing effectively with insurance programs for financing the costs of health care.
3. All appropriate measures be utilized to discourage insurance plans or programs that might encourage such practices which classify as hospital services those professional services which can only be performed legally by licensed physicians.
4. The American Medical Association continue and encourage constituent associations and component societies to foster free competition among all legitimate types of health insurers which preserve the private practice of medicine.
5. Where constituent associations and component societies choose to endorse plans or programs, the criteria established for recognition or approval should not impose conditions which preclude endorsement to any legitimate type of insurer.
6. All insurers be required to adhere to the same code or standards of advertising and sales methods prescribed by the insurance regulatory authorities. Constituent associations and component societies electing to approve, sponsor or endorse certain plans or types of plans should consider the withdrawal of such approval, sponsorship or endorsement whenever such plan or program persists in false, misleading, or deceptive advertising or sales methods.
7. Physicians be ever mindful of their moral responsibility for charging fees based upon the intrinsic value of services rendered since the existence of insurance should alleviate the economic burden for the individual and should not result in an increase in the customary or reasonable charge.
8. Although encouraging progress is being made in the extension and improvement of insurance available for the protection of the aged, the impaired person and those living in remote areas, the American Medical Association, constituent associations and component societies should continue to cooperate fully with insurers in their efforts to insure persons with special problems of coverage.
9. All constituent associations and component societies maintain (to the extent not covered specifically under recommendation #2 above) active committees to meet with representatives of insurers and hospitals for consultation and the exchange of information on problems of mutual concern, the solution of which is in the public interest.

recommendations

INDUSTRY PROGRAMS

1. The committee recommends that immediate steps be taken to construct a program of active cooperation between the American Medical Association and the entire medical profession to resolve the problems mentioned in this report.
2. The appropriate facilities of the A.M.A. should be utilized to implement and make effective the statement on *Scope, Objectives, and Functions of Occupational Health Programs:*
   (a) Within the medical and allied professions,
   (b) Within industrial management in industries of all sizes (National Association of Manufacturers, American Management Association, U. S. Chamber of Commerce, and their state counterparts),
   (c) Within organized labor through its medical advisors, union publications, top level meetings, etc.

   The *purposes* of this recommendation are to improve relationships between existing occupational health programs and practicing physicians; to eliminate unethical practices on the part of both; remedying deficiencies and excesses in such programs; promulgating the advantages of close rapport between industrial medical programs and county medical societies; to discourage combining plant and personal physicians; to encourage direct professional relationships between plant physicians and family physicians; to minimize the amount of definitive treatment for non-occupational conditions in the industrial health programs; to encourage in every way possible fair and honest dealing between private physicians and industry, and to encourage the establishment of proper and adequate occupational health programs in industries of whatever size.
3. The same appropriate facilities of the A.M.A. and its constituent associations and their component societies should be utilized to implement and make effective the statement on *Medical Relations in Workmen's Compensation:*
   (a) Within the medical and allied professions,
   (b) Within the International Association of Industrial Accident Boards and Commission,
   (c) Within the casualty insurance industry,
   (d) Within organized labor and management.

   The *purposes* of this recommendation are to remedy existing and glaring deficiencies in statutes and administration of the 54 workmen's compensation jurisdictions; to bring sound medical judgment to bear on their decisions and administration; to assure free choice of physician as described in the above statement, and to assure prompt restoration to gainful employment in all possible cases.
4. We recommend that industrial physicians be urged to place their medical findings in the hands of an employee's personal physician when requested by that physician and his patient.
5. The Board of Trustees should continue to encourage and support the Council on Industrial Health and the Council on Medical Service in their on-going programs of research, investigation, and education.

recommendations

STUDENT HEALTH SERVICES

Continued and intensified effort on a national level is urged to cope with the changing problems in this field. The committee recommends also that close liaison with these plans be maintained by local medical societies to the end that suitable health programs and student health education may be developed and perfected in keeping with local practice and policies.

It is suggested further that the American Medical Association intensify its activity in this field in order to keep the medical profession informed of developments.

The proper relationship between the medical profession and student health services should be one comprising study and participation; encouragement and understanding, and consultation and advice.

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